PROVIDER DAILY CLOSURE FORM

YOUR NAME _____

FACILITY NAME (If different from your name) _____

SSN/FEIN NUMBER _____COUNTY _____

TELEPHONE NUMBER _____FAX _____

EMAIL _____

ADDRESS _____

CITY _____ STATE _____ ZIP_____

Use this form to list your DAILY closure days (i.e. Holidays). Also complete this form to report any EMERGENCY CLOSURES within a 12-month period. List the date and **check** if it is a daily closure or emergency closure. **Any change in closure days must be reported to the CMA in writing, in advance of the change.**

The Child Care Management Agency can pay for up to 3 full weeks' vacation within a fiscal year. Provider must enter VACATION dates into the Alabama Time and Attendance System Provider Web Portal

1. _____	☐ DAILY CLOSURE	☐ EMERGENCY CLOSURE
2. _____	☐ DAILY CLOSURE	☐ EMERGENCY CLOSURE
3. _____	☐ DAILY CLOSURE	☐ EMERGENCY CLOSURE
4. _____	☐ DAILY CLOSURE	☐ EMERGENCY CLOSURE
5. _____	☐ DAILY CLOSURE	☐ EMERGENCY CLOSURE
6. _____	☐ DAILY CLOSURE	☐ EMERGENCY CLOSURE
7. _____	☐ DAILY CLOSURE	☐ EMERGENCY CLOSURE
8. _____	☐ DAILY CLOSURE	☐ EMERGENCY CLOSURE
9. _____	☐ DAILY CLOSURE	☐ EMERGENCY CLOSURE
10. _____	☐ DAILY CLOSURE	☐ EMERGENCY CLOSURE
11. _____	☐ DAILY CLOSURE	☐ EMERGENCY CLOSURE
12. _____	☐ DAILY CLOSURE	☐ EMERGENCY CLOSURE
13. _____	☐ DAILY CLOSURE	☐ EMERGENCY CLOSURE

I certify if I change these daily closure days, I will notify the CMA in writing, in advance of the change. I further certify that notice of my scheduled closure days will be provided to the parents of all children enrolled in this facility.

_____ _____

Signature of Provider or Owner Date