Schedule 4

Form for Notification of Proposed Change In Circumstances

|  |  |
| --- | --- |
| **Name of Service you are Registered as** |  |
| **Tusla Reference Number** | TU |
| **Address of Service** |  |
| **Phone Number of Registered Provider** |  |
| **Email Address of Registered Provider** |  |

**Please tick (✓) column(s) of the proposed change in circumstances you wish to notify.**

**Please specify using the below lists:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Legal Requirements** |  |  | **Additional Changes you wish to provide** |  |
|  | **Summary of reason for notification** | **✓** |  | **Summary of reason for notification** | **✓** |
| 1 | Change of Service Name |  | 9 | Change in Email Address |  |
| 2 | Change of Service Address |  | 10 | Adding an Additional Service Type |  |
| 3 | Change of Registered Provider |  | 11 | Change in Hours of Operation |  |
| 4 | Change in Legal Name of Company |  | 12a | Addition of a Session (Sessional Services only) |  |
| 5 | Change of Person in Charge |  | 12b | Hours of Operation for Additional Session |  |
| 6 | Change in Number of children that can be accommodated |  | 13 | Change in Phone Number of Service |  |
| 7 | Change in Age Profile of children for which the service is registered to provide services |  | 1`4 | Change in Mobile Number of Service |  |
| 15 | Change in Mobile Number of Registered Provider |  |
| 8 | Change in Service Type |  | 16 | Change in Number of Staff Employed |  |

**Note: If the proposed change in circumstance is between category  1 and category  10 inclusive you are obliged to  submit the Supplementary Information  Form below, for your application for change to be processed.**

|  |  |  |
| --- | --- | --- |
| **Name of Service as per Register:** | | |
|  | **Current information on Register which you propose to change** | **New Information which is proposed to be entered on Register** |
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|  |  |  |
|  |  |  |

Printed Name of Registered Provider.....................................................................................................

Signature of Registered Provider............................................................................................................

Date.........................................................................................................................................................