

**GOVERNMENT OF THE DISTRICT OF COLUMBIA  
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION  
DIVISION OF EARLY LEARNING  
DC CHILD CARE SUBSIDY PROGRAM ATTENDANCE FORM FOR TRADITIONAL SERVICES**

\* Please PRINT or TYPE

<b>NAME OF PROVIDER AND ADDRESS:</b>			<b>CAPITAL QUALITY RATING:</b>										<b>WARD:</b>			<b>LICENSE NUMBER:</b>					<b>LICENSE CAPACITY:</b> _____ # of Infants: _____																		
			<b>TELEPHONE NUMBER:</b>										<b>FAX NUMBER:</b>								<b>LICENSE EXPIRATION DATE:</b>																		
<b>SITE NAME AND ADDRESS:</b>			<b>SIGNATURE OF PERSON CERTIFYING REPORT</b>  I the undersigned verify that this information is correct and accurate. * Reporting of inaccurate information may result in termination of provider agreement and/or referral for investigation to the Office of the State Superintendent of Education (OSSE).  _____ Date Authorized Representative																		<b>MONTH AND YEAR OF REPORT:</b>																		
																					<b>TOTAL NUMBER ENROLLED</b> Inf: _ Sac: __ Tod: __ Pre: ____ HS: ____																		
<b>CHILD'S NAME</b> Alphabetize by Last Name		<b>CHILD's SSN</b> (LAST 4 Digits)	<b>AGE</b>	<b>1<sup>ST</sup> WEEK/DATES</b>							<b>2<sup>ND</sup> WEEK/DATES</b>							<b>3<sup>RD</sup> WEEK/DATES</b>							<b>4<sup>TH</sup> WEEK/DATES</b>							<b>5<sup>TH</sup> WEEK/DATES</b>							<b>COMMENTS</b>
				S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	

This form must be returned by the fifth working day of each month. Failure to return this form will result in delay of payment.

RETURN TO: [oats.osse.dc.gov](https://oats.osse.dc.gov) • Fax 1-800-856-3106 • [osse.attendancereportsubmission@dc.gov](mailto:osse.attendancereportsubmission@dc.gov)

U: Unexcused Absent     EX: Excused Absent     AC: Approved Closure     UC: Unapproved Closure     H: Holiday     T: Terminated     E: Enter

Blank box indicates child present for the day.

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			S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	

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