Date Received by MC3

Child Care Attendance Record

Marin Child Care Council

1600 Los Gamos Dr. #365, San Rafael, CA 94903

415.472.1092

MC3 Use Only

Month: ____________________ **Year** __________

Child Care Provider: ______________________________

Address: ______________________________

City/State/zip: ______________________________

Child's Name: ______________________________

Date of Birth: ______________________________

Parent's Name: ______________________________

Phone: ______________________________

Type of Care (circle one) Center *Licensed Family CC* *Exempt (friend/relative)*

Actual in and out times must be indicated below each day (do not pre-fill schedule). Please make sure forms are complete and accurate BEFORE submitting. **Attendance Records are due by the 5th of the month** following care. We must receive originals, not copies or faxes. Each day the child does not use care as scheduled, please indicate the reason for the absence (ie: parent/child sick, medical appt., family vacation, provider closed). Providers must notify MC3 after 3 consecutive unexcused absences (when parent has not notified provider with reason).

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Weekly Total
___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___	___ to ___	
___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	
___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	
___ to ___ ___ to ___	___ to ___ ___ to ___	to ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	
___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	
___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	___ to ___ ___ to ___	

Full signatures are required below. Parent and Provider must sign this section of the Attendance Record on or after the last day of care provided during the month or it will be considered incomplete.

I, (parent/provider) declare under penalty of perjury under the laws of the United States and the state of California that the facts contained in this Attendance Record are true, correct and complete and that the provider named on this form provided the child care.

______________________________ __________

Parent Signature Date

______________________________ __________

Provider Signature Date

Total billed by provider:

Please indicate amount due or attach invoice

➤ **due for this month: $** __________

MC3 use ONLY

- ☐ **Full Time Monthly Rate** $________/month
- ☐ **Full Time Weekly Rate** $______ [X] ____ # of wks $_____
- ☐ **Daily Rate** $______ [X] _____ # of days $__________
- ☐ **Part Time Monthly Rate** $______/ month
- ☐ **Part Time Weekly Rate** $______/ [X] ______ # of wks $________
- ☐ **Hourly Rate** $______[X] ______# of hours $_______
- ☐ **Adjustment Factor** __________

Comments: ______________________________

CM:

Total Due to Provider____________ **Family Fee**____________ **Total to be paid by MC3**____________