CHILDCARE PROVIDER CLAIM FORM

west lothian college

Name of Childcare Provider: _____

Address of Childcare Provider: _____

Childcare Claimed for Month of: _____ **2020-21**

Name of Child(ren): _____

Name of Parent: _____

Date	Child(ren)	Times From	Times To	Total Hours	Total Cost
				TOTAL	

Signed by: _____

Name : _____
(Please Print)
Date: _____

For office use only	
LPCG	
Childcare Fund	
Total to Pay	