☐ Initial ☐ Unannounced Full/Partial ☑ Follow-up ☐ Location Change ☐ Investigation ☐ Other _____

# SUPPLEMENTAL REPORT OF INSPECTION

Name of Program/Provider: The Learning Experience - Stamford Date: 3 4 25 Time: 1145am

Location Address: 421 Atlantic St Stamford Telephone #: 203 595 5271

e-mail address: Stamford@tlechildcare.com License #: 705885 Expiration Date: 11 30 28

Capacity: 123/72 # of Children Present: 90/55 # of Staff Present: 20

| | |
|---|---|
| ***Consent to Inspect Family Child Care Home*** | *I agree to allow the Office of Early Childhood to have access to and inspect this facility and all child care records as required by Family Child Care Home Regulations.* ***Provider/Applicant/Substitute's Signature*** _____ |

Purpose of visit: Follow Up to 225.25 inspection on safe sleep. #13C

Observations/Corrections needed:

13C(g)(3) OK at inspection

**S = Substantiated** **NS = Not Substantiated** **P = Pending (if applicable)**

Operators/providers are required by regulations and statutes to be in compliance at all times.

CORRECTIVE PLAN SHALL BE RETURNED TO OEC BY: N/A

Signature: _____
*(OEC Representative)*
Print Name: Lori Mangano

Signature: _____
*(Person in Charge)*
Print Name: Alliyah Imm Lewis