TRAINING REGISTRATION FORM

TRAINING NAME	DATE	FEE

NAME:

CENTER NAME (IF APPLICABLE):

ADDRESS (STREET):

ADDRESS (CITY, STATE, COUNTY):

PHONE: EMAIL:

I AM A... (*please check all that apply*)

- ☐ CENTER DIRECTOR
- ☐ CENTER STAFF (TEACHER)
- ☐ CENTER STAFF (ASSISTANT)
- ☐ FAMILY CHILD CARE STAFF
- ☐ LICENSE-EXEMPT (FRIEND, FAMILY, NEIGHBOR)
- ☐ OTHER:

TIME IN POSITION:

DO YOU ACCEPT CCAP CHILDREN (SUBSIDY)?: ☐ YES ☐ NO

ARE YOU A DCFS LICENSED PROGRAM?: ☐ YES ☐ NO

WHAT IS THE PRIMARY AGE YOU SERVE?:

☐ INFANTS ☐ TODDLERS ☐ TWOS ☐ PRE-SCHOOL ☐ SCHOOL-AGE

GATEWAYS REGISTRY #: METHOD OF PAYMENT:

AMOUNT ENCLOSED: $ AMOUNT IN TRAINING COUPONS : $

PLEASE SUBMIT TRAINING REGISTRATIONS TO... Training: Community Child Care Connection
901 S. Spring St, Suite B
Springfield, IL 62704