

# PROFESSIONAL DEVELOPMENT / PROGRAM IMPROVEMENT FUND PARTICIPANT FORM (July 2009 – June 2010)



## 4-C: Community Coordinated Child Care

- TO BE COMPLETED BY EACH INDIVIDUAL WHO ATTENDS AN ON-SITE IN-SERVICE/TRAINING EVENT.
- PLEASE MAKE COPIES AS NEEDED.
- Please refer to Professional Development/Program Improvement Guidelines & Requirements, Page 3, #3, F for assistance in completing this application. Type or print using black ink.

### STEP 1: Event Information

Sponsoring Center or Association: \_\_\_\_\_

Topic Title: \_\_\_\_\_

Date of Event: \_\_\_\_\_

How many hours of training did you receive? \_\_\_\_\_

Type of Credit: \_\_\_\_\_

### STEP 2: Personal Information (home contact information)

Applicant First Name: \_\_\_\_\_

Applicant Last Name: \_\_\_\_\_

Applicant Street Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

County: \_\_\_\_\_

Phone Number: (    ) \_\_\_\_\_

Role:  Center Director  Center Teacher  Center Assistant Teacher  Family Child Care Owner  Family Child Care Staff  Other \_\_\_\_\_

What are the ages of children YOU currently work with directly? (check all that apply):

- Infants (6 wks. – 14 mos.)   
  Toddlers (15-23 mos.)   
  Twos (24-35 mos.)   
  Pre School (36-59 mos.)   
  School Age (60 mos. – 12 yrs.)   
  None (for program staff who do not directly work with children)

I have requested Professional Development funds to: (check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Implement better practices               | <input type="checkbox"/> Increase my level to receive a Great START bonus |
| <input type="checkbox"/> Meet DCFS training requirements          | <input type="checkbox"/> Meet accreditation standards                     |
| <input type="checkbox"/> Obtain qualifications for a new position | <input type="checkbox"/> Assess a program                                 |
| <input type="checkbox"/> Obtain a credential (new or renewal)     | <input type="checkbox"/> other _____                                      |
| <input type="checkbox"/> Earn college coursework credit           |   |

### STEP 3: Program Information (please complete the following for your current place of employment or family child care business)

Name of Business (if licensed, as appears on license): \_\_\_\_\_

Business Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

County: \_\_\_\_\_

Phone Number: (    ) \_\_\_\_\_

Fax Number: (    ) \_\_\_\_\_



### STEP 3: Program Information (continued)

What date did you begin employment at this site? \_\_\_\_\_ Month: \_\_\_\_\_ Date: \_\_\_\_\_ Year: \_\_\_\_\_

Address Preference:  Use applicant address  Use program address

Email Address: \_\_\_\_\_  Personal  Program

Program Type:  Center  Family Child Care  Group Family Child Care  
 Head Start  Preschool for All

Status:  License-Exempt  Licensed \_\_\_\_\_ What is the total **current** enrollment in your program? \_\_\_\_\_  
DCFS License Number

**Complete the remainder of Step 3 ONLY if you are an association member:**

Does the program you work for currently care for children whose care is paid for by the IDHS Child Care Assistance Program (subsidy) and/or IDCFS?

Yes  No

### STEP 4: Authorization

*I have attended the On-Site In-Service/Training Event listed in Step 1. I certify that the above information is true and accurate, that I have not been indicated of child abuse and neglect and that my name is not listed on the child abuse tracking system.*

\_\_\_\_\_  
Applicant Signature Date