COMMUNITY
CHILD CARE CONNECTION
Child Care Resource & Referral

TRAINING REGISTRATION FORM

TRAINING NAMES

1.	Training Date:
2.	Training Date:

Full Name :

Center Name (If applicable) :

Address :

City :

ZIP/Postal Code :

State/Province :

Country :

Phone Number :

Date of Birth : / /

Email: :

I AM A. . (PLEASE CHECK ALL THAT APPLY)

- ☐ Center Director
- ☐ Center Staff (Assistant)
- ☐ License-Exempt(Friend, Family, Neighbor)
- ☐ Center Staff(Teacher)
- ☐ Family Child Care Staff
- ☐ 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 : $