

CCCC Training Registration Form

Please complete the following information:

Name: _____

Mailing Address: _____ County: _____

City, State, Zip: _____ What address is this? Home or work

Telephone #: _____ Cell phone #: _____

Email address: _____

I am a: Center Staff (Teacher) Center Director Center Name: _____

Center Staff (Assistant) Family Child Care Owner

Family Child Care Staff Other: please explain _____

Time in position: _____ Do you accept CCAP children? (subsidy) Yes or No

Are you a DCFS licensed program? Yes or No

Primary age you serve: Infants Toddlers Twos Pre-school School-Age

Please register me for the following workshops:

Date	Training	Cost

Please return this form and payment to:

Training
Community Child Care Connection, Inc.
919 S. Spring Street
Springfield, IL 62704

Total amount of money enclosed:
Payment Method: check money order certificate