

EMPLID: _____

ACCCO

DATE: _____



CHILD CARE CENTER OPERATIONS APPROVAL FORM

Student Number: _____

Personal Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Date of Birth: _____ Social Security #: _____

E-Mail Address: _____

Additional Enrollment Information:

Do you have:

An active Staff Credential? ____Yes ____No DCF Number: _____

DCF 45 Hr. Training? ____Yes ____No

8 Hr. Special Needs? ____Yes ____No

5 Hr. Emergent Literacy for VPK? ____Yes ____No

Florida Standards 8/5/3 Course? ____Yes ____No

5 Hr. Mathematical Thinking for Early Learners? ____Yes ____No

5 Hr. Language and Vocabulary in the VPK Classroom? ____Yes ____No

Trauma Informed Care Training? ____Yes ____No

Employer Information:

Name: _____ Hire Date: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____