

Child Care Connection

Early Childhood Institute for Professional Development

WORKSHOP REQUEST QUESTIONNAIRE

Thank you for your interest in planning your staff professional development with us. This form will assist us in identifying your needs, resulting in a more effective and results-focused training opportunity for your staff or parents. After completing this form, you may mail or e-mail to the following: **Child Care Connection, Attention: Cindy Jackson, 1001 Spruce Street, Suite 201, Trenton, NJ 08638** or cindyjackson@ccc-nj.org. Your training event cannot be finalized until this information is received by our office.

Provider Information

Center Name:	
Contact Name:	
Address:	
Phone:	
Fax:	
E-mail:	
Preferred Date(s) and Time(s):	

	Criteria	Response
1	What topic would you like us to present?	
2	Please indicate whether the training audience will be staff, parents, or both.	
3	Is this the first time you are offering this training?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	If you answered "No" to Question 2; Is the training a follow-up or has the staff and/or center dynamics changed, warranting re-training?	
5	Please indicate the number of staff by age range at your site.	___ Infants ___ Toddlers ___ Preschool ___ School-aged ___ Other (Admin. Support Staff)
6	How many participants are you expecting to attend the training?	
7	What amount of time have you allotted for this training?	
8	Please describe the room in which the training is taking place.	

What are you hoping to achieve as a result of this training?

Please sign and return to Child Care Connection. You will be contacted to discuss our fee schedule once we receive this form. Once payment arrangements are made, we will return a copy of this form as confirmation. Again, thank you for selecting Child Care Connection for your training needs. If anything changes or if you have any questions, please call Cindy Jackson at 609-989-7770, Ext. 139. Thank you.

Signatures/Approval

Contact Person: _____ **Date:** ____ / ____ / ____

Training Director: _____ **Date:** ____ / ____ / ____

Approved: Yes No

Fee: _____

Date: _____

Topic: _____

Assigned Facilitator: _____