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: Emily Schwartz, 1001 Spruce Street, Suite 201, Trenton, NJ 08638 or** emilyschwartz@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?	☐ Yes ☐ 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?

Are you interested in arranging follow-up technical assistance related to your training topic? Please describe your needs.

Please sign and return to Child Care Connection. You will be contacted to discuss our fee schedule once we receive this form. Once topic and payment arrangements are made, you will receive a confirmation letter. Again, thank you for selecting Child Care Connection for your training needs. If anything changes or if you have any questions, please call Emily Schwartz at 609-989-7770, Ext. 126. Thank you.

Signatures/Approval

Contact Person: _____ **Date:** _____

Training Director: _____ **Date:** _____

CCC Office Use:

Approved: ❑ Yes ❑ No

Fee: _____

Date: _____

Topic: _____

Assigned Facilitator: _____