

REGISTRATION
Fall 2009 Best Care Connected

Instructions: This form will be electronically scored so please mark the desired answer by filling in the corresponding circle with a dark pencil or pen like this: “●” Do not “X” or “√” the circles.

1. Fill in the circle that **BEST** describes your position:
- Director or Assistant Director
 - Program Coordinator or Administrator
 - Teaching Staff
 - Program Support Staff
 - Family Child Care Provider
 - Other: _____
2. I have been in the child care/early education profession:
- Less than 1 year
 - 1-5 years
 - 6-10 years
 - 11-15 years
 - 16-20 years
 - 21-30 years
 - Over 30 years
3. Fill in the circle that **BEST** describes the age group you work with:
- Infants/toddlers (6wks-3 years old)
 - Preschool (3-5 years old)
 - School Age (6-12 years old)
 - I do not work directly with children.
4. I work in a: (*Fill in ONE*)
- Rural area or Small Town < 2,500
 - Large Town (2,500 – 9,999)
 - Small City (10,000 – 49,999)
 - Large City (50,000 & over) or suburb of a large city
5. I am: (*Fill in ONE*)
- Male
 - Female
6. My race/ethnicity is: (*Fill in ONE*)
- Black (non-Hispanic)
 - White (non-Hispanic)
 - Hispanic/Latino(a)
 - American Indian or Alaskan Native
 - Asian or Pacific Islander
 - Multi-Racial
7. My education level is: (*Fill in ONE*)
- High School Graduate/GED
 - CDA
 - Associate Degree
 - Bachelor's Degree
 - Graduate Degree
8. Do you have access to a printer?
- Yes
 - No

Please mail your registration form to:
Sherry Jones
U of A Cooperative Extension Service
P.O. Box 391
Little Rock, AR 72203

Thank You!

Please Turn Over





TRAVELING ARKANSAS' PROFESSIONAL PATHWAYS

Attendance Form

Practitioner Application

Best Care Connected Fall 2009

Statistical Information:

This information is used for reporting purposes and for recording attendance. **PLEASE PRINT.**

Full Name (First Middle Last): _____

PO Box/Street: _____

City: _____

State: _____

Zip Code: _____

County: _____

E-Mail: _____

Date of Birth: _____ / _____ / _____

Primary Phone Number: _____

Work Phone Number: _____

COMPLETE

TAPP Registry ID Number: _____

ONLY ONE

Last 5 Digits of Social Security Number: X X X—X ____—____—____—____

I am a current member of the TAPP Registry.

I am a current member of the TAPP Registry; please update my information to reflect the above.

(OPTIONAL)

TRAVELING ARKANSAS' PROFESSIONAL PATHWAYS REGISTRY

I am **NOT** a current member of the Traveling Arkansas' Professional Pathways Registry. Please **ACCEPT** this form as my initial application to become a member.

(By marking this box and signing below, you will become a member of the TAPP Registry at the *Basic Awareness* level.)

Please send me information on becoming a member at the Orientation, Intermediate, or Advanced levels of the SPECTRUM. (You will receive a current copy of the SPECTRUM and a complete application. Incentives offered by the TAPP Registry will only be issued to those members at the Basic Orientation level and beyond.)

Signature

Date

**TRAINER
USE
ONLY**

1 2 3 4 5 6 7 8 9 10
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IMPORTANT NOTICE

Child Care Licensing has a basic requirement of 10 hours of DCCECE approved professional development annually for licensed facilities. Quality Approved Programs have a basic requirement of 15 hours of early childhood education professional development annually. ABC Program staff are required to obtain 30 hours of staff development on topics pertinent to early childhood, approved by DCCECE. Membership in the TAPP Registry requires 15 hours of registered professional development annually.