

Alaska Child Care Resource and Referral Network- Alaska IN!

PROVIDER TRAINING PLAN

Provider's Name: _____ Phone: _____

Mailing Address: _____

Child's Name: _____ Birth Date: _____

Parent/Legal Guardian's Name: _____

Child Care Referral Counselor: _____ Phone: _____

Training Requirements

Classes Completion Date: _____

Specialized Training Completion Date: _____

On-Site Consultations Completion Date: _____

Distance Delivery Completion Date: _____

Other Training Completion Date: _____

Relevant Training Completed: _____

Date required training must be completed: _____

The following parties agree upon this *Provider Training Plan* (sign and date).

Provider: _____ Date: _____

Child Care Referral Counselor: _____ Date: _____



South Central
Child Care Connection, Inc.
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Southeast
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Northern/Interior
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