The Commonwealth of Massachusetts
Department of Early Education and Care

STAFF INFORMATION FORM

(This form must be completed by each staff person)

PROGRAM NAME: _____

Name:	Date of Birth:
Address:	Telephone Number:
Date of Hire:	Social Security #:(optional)
Current Position:	Supervisor's Name:

ADMINISTRATIVE AND TEACHING STAFF:

Circle age group(s) you are caring for:

Infant (birth - 15 mos.)
Toddler (15 mos. - 33 mos.)
Preschool (2 yrs. 9 mos. - K.)
School Age (5 yrs. - 14 yrs.)
Multi-Age Group (birth -14 yrs.)
Infant / Toddler (birth - 2 yrs. 9 mos.)
Toddler / Preschool (15 mos. - K.)
Preschool / SA (2 yrs. 9 mos. - 9 yrs.)
Kindergarten / SA (5 yrs. - 14 yrs.)

Do you have a Department of Early Education and Care or Office of Child Care Services Certificate of Qualifications?
No_____ Yes_____ Applied_____

Certificate #_____ Level_____(Copy of Certificate, if applicable, must be on file at center)

Please list any licenses, certifications, or registrations you have (i.e. teacher certification, social worker's license, etc.)

_____

_____

Date of EEC Professional Registry_____

Date of EEC Educator Orientation (if applicable)_____

I attest that the above information is, to the best of my knowledge, true and accurate.

_____ _____
Signature Date