PY 19-20
Rev. 07/19

Please mail / fax / or e-mail to :
A-STATE Childhood Services Attn: TA Coordinator
P.O. Box 808 State University, AR 72467
E-Mail: ta@astate.edu
Telephone (870) 972-3055 Toll Free (888) 429-1585
Fax (870) 972-3556 Website: http://chs.astate.edu

Regular

REQUEST FOR TRAINING AND/OR TECHNICAL ASSISTANCE

License Number: _______________ Agency Administering the Program (if applicable) : ______________________________
(i.e. School District, Educ. Coop, Church, N/A)

Name of Site: ______________________________ County: ______________

Name of Program Administrator: ______________________________ Title: ______________

Admin. Office Telephone: ______________________ Site Telephone : ______________________

Admin. E-mail Address: (where review report will be sent) ______________________________

PHYSICAL Address of Center:

____
Street

____
City State Zip Code

MAILING Address of Center: (If Different)

____
Street/P.O. Box

____
City State Zip Code

DHS Licensing Specialist: ______________________ CCLS Phone #: ______________________

TA Specialist will work with: ______ Infant/Toddler Rooms ______Preschool Rooms

______ Family Home ______ School Age/Out of School Time ______ Administrator

Please select a maximum of 2 topics as the focus of this TA visit.
Additional visits may be required to address additional topics.

	Minimum Licensing		Conscious Discipline *		ECERS		Observation / Documentation
	Supervision		Curriculum		ECERS-3		Portfolio
	Transportation		Schedule		ITERS		Better Beginnings Level _____
	Behavior\Guidance		Transitions		FCCERS		BB General Information
	Ratio		Room Arrangement		SACERS		BB Application
	Playground		Review ERS Summary Report		SAPQA		PAS-Program Scale
	Administrative		Work Sampling		YPQA		BAS-Family Home Scale
	Other Please List:						OUNCE

Does this program participate in any of the following? **Check all that apply**

	Preschool Development Grant (PDG)
	ABC or ABCSS Program
	Federal Pre-k Program
	Better Beginnings Level ______
	Endeavour
	Voucher Program
	Head Start
	Special Project
	Other

What do you hope will be accomplished during this visit?

***Conscious Discipline TA requires that you have attended the 6 day Conscious Discipline training.**

______________________________ ______________
Name and title of person making request Phone Number

To be completed by Childhood Services:

______________ ______________ ______________
Control Number Region / Coordinator Date Assigned