

**CCSN PARTNER
INFORMATION SHEET**

Thank you for helping us bring a level of accountability and professionalism to the child care centers we serve. Our CCSN Partner Program is a win/win opportunity for everyone. As a CCSN Certified Partner you will receive...

- ✓ high quality educational material, with new training titles added each year
- ✓ partner discounts on most printed and online training products
- ✓ previews of new products
- ✓ personal support and additional resources not available to individual providers

CHOOSE THE MEMBERSHIP LEVEL THAT BEST FITS YOU

1. AGENCY PARTNER (AP)
Agency Partners (AP) are those **Centers** who are purchasing training material for **ONE** center.
 ___ Yes, I would like to be an **Agency Partner (AP)**
 Requires a \$20 Annual Membership Fee (waived until 01/2020)

2. TRAINING PARTNER (TP)
Training Partners (TP) are those **Trainers** who are purchasing training for **MULTIPLE** centers.
 ___ Yes, I would like to be a **Training Partner (TP)**
 Requires a \$77 Annual Membership Fee (waived until 01/2020)

PLEASE NOTE:

This form **MUST** be submitted to become a CCSN certified partner and to receive partner benefits.

QUALIFICATIONS

ALL CCSN Certified Partners are required to have at least one staff that meets, or exceeds, the credentials necessary to serve at the director level including, but not limited to:

- Bachelor's degree in Early Childhood and/or
- CDA Credential and serving as a director and/or
- 5 or more years of experience in the child care or education field and/or
- Is a registered trainer in the state the state they train in

PERSONAL INFORMATION

Please use Trainer, Owner or Agency Director information

NAME: _____

COMPANY: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP** _____

EMAIL: _____

PHONE: _____

E D U C A T I O N :

Degree or Certification: _____ **Year Completed:** _____

Degree or Certification: _____ **Year Completed:** _____

Other _____ **Year Completed:** _____

E X P E R I E N C E :

Employer: _____ **Job Title:** _____

Dates Employed: _____ **Responsibilities:** _____

Employer: _____ **Job Title:** _____

Dates Employed: _____ **Responsibilities:** _____

Employer: _____ **Job Title:** _____

Dates Employed: _____ **Responsibilities:** _____

MAIL completed form to: Robin Madson
 P.O. Box 322, Waupaca, WI 54981; FAX to 715-258-9048
 or complete online at www.impact-publications.com