

ENROLLMENT FORM – COMMACK

March 2019-June 2019

Please complete and return **with fees**, if required, to *Child Care Council of Suffolk, 60 Calvert Avenue, Commack, N.Y. 11725* or fax enrollment form with credit card info: 1-631-462-2017. **(Make checks payable to: Child Care Council of Suffolk - No fee will be refunded unless training is cancelled).** No confirmation will be sent. If you plan to use an EIP award, the award letter must accompany this form. **IF PAYING MEMBER FEE, A COPY OF THE MEMBERSHIP CARD MUST ACCOMPANY THIS FORM.** *There will be a \$20 fee for any returned checks.*

Name: Last _____ First _____

THERE MUST BE AN INDIVIDUAL FORM FOR EACH PERSON REGISTERING

Home Address _____ City _____ Zip Code _____

Home Phone _____ Work Site _____ Work Phone _____

Cell Phone: _____ Email _____

Check if Enrolling	Class Date	WORKSHOPS IN COMMACK	Class Time	Member Fee	Non Member Fee	Amount Of Payment
	3/13/19	Infant/Child/Adult CPR	6:30-9:30 pm	\$60	\$100	
	3/27/19	Pediatric First Aid	6:30-9:30 pm	\$60	\$100	
	4/3/19	Infant/Child/Adult CPR	6:30-9:30 pm	\$60	\$100	
	4/10/19	Pediatric First Aid	6:30-9:30 pm	\$60	\$100	
	5/8/19	Infant/Child/Adult CPR	6:30-9:30 pm	\$60	\$100	
	5/15/19	Pediatric First Aid	6:30-9:30 pm	\$60	\$100	
	5/22/19	Nurturing Little Scientists and Mathematicians	6:30-8:30 pm	\$40	\$80	

FOR CREDIT CARD CHARGES: MasterCard/Visa

Name of Cardholder _____ Billing Address _____

City/Zip: _____

Amount of Charge _____ Expiration date _____

(FOR OFFICE USE ONLY: Auth. Code #: _____ Date: _____ Acct. Number (Last 4): _____)

Credit Card Number _____

MEMBERSHIP APPLICATION

Membership Name: _____ Home Address: _____

City/Zip: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

PLEASE CIRCLE YOUR MEMBERSHIP CATEGORY BELOW AND ENCLOSE THE APPROPRIATE FEE

Individual \$40	Family Provider \$40	Group Family Provider \$70
Center/School/Camp \$125	Child Care Center (2+) \$250	