

Early Educator Certification (EEC) Update Form

Instructions: Please complete this form to update your records with the EEC office. Return forms to the address located below.

I. Contact Information

Date:		County of Residence:		Last Four Digits of Social Security Number:	
First Name:		Middle Name:	Last Name:		Maiden Name (if applicable):
Mailing Address:				City:	State:
Home Phone: () ()		Cell Phone: () ()		Email Address:	

II. Employment Information

<input type="checkbox"/> DCD licensed child care facility <input type="checkbox"/> unlicensed child care program <input type="checkbox"/> K-3 classroom <input type="checkbox"/> afterschool program	<input type="checkbox"/> child care resource and referral agency <input type="checkbox"/> community college, college or university <input type="checkbox"/> local or state partnership for children <input type="checkbox"/> federal, state or government agency <input type="checkbox"/> other employment: _____
<input type="checkbox"/> college student not employed in field <input type="checkbox"/> high school student not employed in field <input type="checkbox"/> currently work in another field, but intend to work directly with or on behalf of children ages birth to twelve <input type="checkbox"/> unemployed, but intend to work directly with or on behalf of children ages birth to twelve	

Employer Name:			County of Employment:		
Employer Mailing Address:			City:	State:	Zip:
Employer Phone: () ()	Employer Fax: () ()	Employer Email Address:		Employment Start Date: ____/____/____	

Position Title:		
<input type="checkbox"/> Assistant Director <input type="checkbox"/> Assistant Teacher/Aide <input type="checkbox"/> Assistant Group Leader <input type="checkbox"/> Director/Administrator <input type="checkbox"/> Education Coordinator <input type="checkbox"/> Family Child Care Provider	<input type="checkbox"/> Floater <input type="checkbox"/> Group Leader (Schoolage) <input type="checkbox"/> Owner/Director <input type="checkbox"/> Program Coordinator <input type="checkbox"/> Teacher/Lead Teacher	<input type="checkbox"/> Agency Director <input type="checkbox"/> Consultant <input type="checkbox"/> Faculty Member <input type="checkbox"/> Professional Development Coordinator/Provider <input type="checkbox"/> Researcher <input type="checkbox"/> Specialist: _____ <input type="checkbox"/> Technical Assistance Coordinator/Provider <input type="checkbox"/> Other: _____
(Please give full position title.)		

DCD Facility License Number: _____	Total Hours Worked Per Week:	How many hours per week are spent directly with children?
<input type="checkbox"/> Check here if you do not work in a licensed child care facility		

Ages of Children With Whom You Work Directly:		
<input type="checkbox"/> Infants <input type="checkbox"/> Twos <input type="checkbox"/> Fours <input type="checkbox"/> Schoolage (Kindergarten to 3 rd grade) <input type="checkbox"/> Not applicable <input type="checkbox"/> Ones <input type="checkbox"/> Threes <input type="checkbox"/> Fives <input type="checkbox"/> Schoolage (4 th grade and above)		

If you work in a classroom or child care home, please indicate funding sources your classroom/home receives:		
<input type="checkbox"/> NC PreK	<input type="checkbox"/> Part B: Preschool Disabilities Program	<input type="checkbox"/> Title I
<input type="checkbox"/> Head Start	<input type="checkbox"/> Part C: Infant/Toddler/CDSA	<input type="checkbox"/> None of the above
<input type="checkbox"/> Don't know		

I, _____ (name), attest that the information provided on this form and the supporting documentation is true to the best of my knowledge. I understand that falsifying any information or documentation may result in the inability to be certified or in the later loss of certification.

Signature

Date

NC Institute for Child Development Professionals | www.ncicdp.org
 Early Educator Certification | PO Box 959 Chapel Hill, NC 27514
info@ncicdp.org | Phone: 919-942-7442 | Fax: 919-442-1998

