Connecticut Office of Early Childhood (Attachment 9e)
Division of Licensing
Consultant/ Head Teacher Data Sheet

PLEASE PRINT - Please Enter Complete Information for Each Consultant and Head Teacher
Enter N/A (Not Applicable) for Questions That Do Not Apply

Name of Person completing this form: _____

Position: _____ Date form completed: _____

Program Name: _____License # _____

Street Address: _____Town: _____CT Zip:_____

Telephone #: (_____)_____-_____ Fax #: (_____)_____-_____ E-mail_____

Health Consultant (Required)

Last name:_____First:_____Middle initial:_____

Resident Street Address:_____Town:_____State:_____Zip:_____

Telephone #: (_____)_____-_____Fax #: (_____)_____-_____E-mail: _____

Work Address: _____Town: _____State: _____Zip:_____

Telephone #: (_____)_____-_____Fax #: (_____)_____-_____E-mail:_____

CT License held: ☐Physician ☐Physician Assistant ☐AP Registered Nurse ☐Registered Nurse

CT Professional License #: _____ License Expiration Date: _____

Early Childhood Education Consultant (Required)

Last name:_____First:_____Middle initial:_____

Resident Street Address:_____Town:_____State:_____Zip:_____

Telephone #: (_____)_____-_____Fax #: (_____)_____-_____E-mail:_____

Work Address: _____Town:_____State:_____Zip:_____

Telephone #: (_____)_____-_____Fax #: (_____)_____-_____E-mail:_____

OEC approval on file: ☐ Yes ☐ No

Name at time of approval if different: _____

PLEASE BE SURE TO COMPLETE THE REVERSE SIDE OF THIS FORM

Social Service Consultant (Required)

Last name: _____First: _____Middle initial: _____

Resident Street Address: _____Town: _____State: _____Zip: _____

Telephone #: (_____)_____-_____Fax #: (_____)_____-_____E-mail: _____

Work Address: _____Town: _____State: _____Zip: _____

Telephone #: (_____)_____-_____Fax #: (_____)_____-_____E-mail: _____

Professional degrees held: ☐BSW ☐BA/ BS - Field of study: _____

☐MSW ☐MA/MS - Field of study: _____

Professional License # (if applicable): _____ Expiration Date: _____

Registered Dietitian Consultant (If applicable)

Last name : _____First: _____Middle initial: ____

Resident Street Address: _____Town: _____State: _____Zip: _____

Telephone #: (_____)_____-_____Fax #: (_____)_____-_____E-mail: _____

Work Address _____Town: _____State: _____Zip: _____

Telephone #: (_____)_____-_____Fax #: (_____)_____-_____E-mail: _____

Professional license held: ☐RD License/ID #: _____ Expiration Date: _____

Head Teacher(s) (Required)

Please complete this section for each Agency Approved Head Teacher at this program. If your program has more than (1) Head Teacher, please submit this information as an attachment.

Last name: _____First: _____Middle initial: _____

Resident Street Address _____Town: _____State: _____Zip: _____

Telephone #: (_____)_____-_____Fax #: (_____)_____-_____E-mail: _____

Work Address: _____Town: _____State: _____Zip: _____

Telephone #: (_____)_____-_____Fax #: (_____)_____-_____E-mail: _____

Department approval on file: ☐No ☐Yes (if yes, please check) ☐Under 3 Years ☐Preschool ☐School Age

Name at time of approval if different: _____

Please return this form to: Connecticut Office of Early Childhood, Division of Licensing, 450 Columbus Boulevard, Suite 302, Hartford, CT 06103 or Fax (860) 326-0552