

STAFF VERIFICATION FORM 2013-14

Date: _____ **Observer:** _____

License Number: _____

Provider/Agency Name: _____

If CB, Room Name: _____

**If CB, Site Supervisor/
Director:** _____

Confirmed Program Hours:	Start Time: End Time:	(Print Name)	(Initials)
Time of Review:	Start Time: End Time:	(Print Name)	(Initials)

<u>Staff Verification</u>	<u>Name</u>	<u>Signature</u>
Lead Teacher:		
Other Teacher:		
Other Teacher:		
Other Teacher:		
Other Teacher:		