Berea Early Childhood Regional Training & Parent Resource Center Library Registration Form

PLEASE PRINT ALL INFORMATION

Date:_____

Personal Information

First Name:_____

Last Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Cell Phone:_____

Email:_____

District/Agency Information

District/Agency Name:_____

_____

Job Title:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Cell Phone:_____

Email:_____

Please complete the following information if you are a college student!

Name of College:_____

Instructor's Name:_____

Student Email Address:_____

Parent's Name:_____

Address:_____

Email:_____

Expected Graduation Date:_____

Campus Number:_____

Phone:_____ Cell Phone:_____

City:_____ State:_____ Zip:_____

I understand that check out time is for a period of two weeks and that resources that are not returned may result in the suspension of the use of the facility for my entire District, Agency, or Campus.

_____   _____
Signed   Date