

**Please mail / fax / or e-mail to :**  
**A-STATE Childhood Services Attn: TA Coordinator**  
**P.O. Box 808 State University, AR 72467**  
**E-Mail: ta@astate.edu**  
**Telephone (870) 972-3055 Toll Free (888) 429-1585**  
**Fax (870) 972-3556 Website: http://chs.astate.edu**

**TA**

**Regular**

**REQUEST FOR TRAINING AND/OR TECHNICAL ASSISTANCE**

License Number: \_\_\_\_\_ Agency Administering the Program (if applicable) : \_\_\_\_\_  
 (i.e. School District, Educ. Coop, Church, N/A)

Name of Site: \_\_\_\_\_ County: \_\_\_\_\_

Name of Program Administrator: \_\_\_\_\_ Title: \_\_\_\_\_

Admin. Office Telephone: \_\_\_\_\_ Site Telephone : \_\_\_\_\_

Admin. E-mail Address: (where review report will be sent) \_\_\_\_\_

**PHYSICAL** Address of Center:

**MAILING** Address of Center: (If Different)

\_\_\_\_\_ Street

\_\_\_\_\_ Street/P.O. Box

\_\_\_\_\_ City State Zip Code

\_\_\_\_\_ City State Zip Code

DHS Licensing Specialist: \_\_\_\_\_ CCLS Phone #: \_\_\_\_\_

TA Specialist will work with: \_\_\_\_\_ Infant/Toddler Rooms \_\_\_\_\_ Preschool Rooms  
 \_\_\_\_\_ Family Home \_\_\_\_\_ School Age/Out of School Time \_\_\_\_\_ Administrator

**Please select a maximum of 2 topics as the focus of this Technical Assistance support.**  
**Additional support may be required to address additional topics.**

Does this program participate in any of the following? Check all that apply

Minimum Licensing	Conscious Discipline *	ECERS-3	Observation / Documentation
Supervision	Curriculum	ITERS	Portfolio
Transportation	Schedule	FCCERS	Better Beginnings Level ____
Behavior/Guidance	Transitions	SACERS	BB General Information
Ratio	Room Arrangement	SAPQA	BB Application
Playground	Review ERS Summary Report	YPQA	PAS-Program Scale
Administrative	Work Sampling	OUNCE	BAS-Family Home Scale

- ABC or ABCSS Program
- Better Beginnings Level \_\_\_\_\_
- Endeavour
- Voucher Program
- Head Start
- Early Head Start
- Special Project
- Other

Other Please List:

What do you hope will be accomplished during this technical assistance?

**\*Conscious Discipline TA requires that you have attended the 6 day Conscious Discipline training.**

\_\_\_\_\_  
Name and title of person making request

\_\_\_\_\_  
Phone Number

To be completed by Childhood Services:

\_\_\_\_\_  
Control Number

\_\_\_\_\_  
Region / Coordinator

\_\_\_\_\_  
Date Assigned