Early Childhood Program
PROGRAM CONTRIBUTION ATTENDANCE REPORT

❑ **Projected** (beginning of quarter) ❑ **Actual** (end of quarter)

Quarter Applied For

❑ April/May/June ❑ July/Aug/Sept. ❑ Oct./Nov./Dec. ❑ Jan./Feb./March

Report Number

This personal information is being collected under the authority of the *Access to Information and Protection of Privacy Act* and will be used to process the funding subsidy. It is protected by the privacy provisions of the Act. If you have questions about the collection, contact the Director of Child Day Care Services, Department of Education, Culture and Employment @ 867-920-3491.

Name of Facility/Operator	
Address	
Telephone	Fax
E-mail	

When completed, send the WHITE copy to the Education, Culture & Employment Office in your region:

Early Childhood Program GNWT - EC&E Box 1406 **Fort Smith**, NT X0E 0P0 Phone: 872-7434 Fax: 872-4507	Early Childhood Program GNWT - EC&E Box 740 **Fort Simpson**, NT X0E 0N0 Phone: 695-7329 Fax: 695-7351	Early Childhood Program GNWT - EC&E Box 1320 **Yellowknife**, NT X1A 2L9 Phone: 767-9356 Fax: 873-0423	Early Childhood Program GNWT - EC&E Bag Service #1 **Inuvik**, NT X0E 0T0 Phone: 777-7436 Fax: 777-7218	Early Childhood Program GNWT - EC&E Box 147 **Norman Wells**, NT X0E 0V0 Phone: 587-7160 Fax:587-2612

Type of Space	1ST MONTH Month						2ND MONTH Month						3RD MONTH Month					
	No. of Spaces	No. of Operational Days	OFFICE USE ONLY Rate		Amount		No. of Spaces	No. of Operational Days	OFFICE USE ONLY Rate		Amount		No. of Spaces	No. of Operational Days	OFFICE USE ONLY Rate		Amount	
Full-time preschool																		
Full-time infant																		
Full-time special needs*																		
Part-time preschool																		
Part-time infant																		
Part-time special needs*																		
After-school																		
After-school special needs*																		
Other, specify:																		

*** NOTE:** Verification from a Health Professional must be provided for all special needs children.

1st Month Total

2nd Month Total

3rd Month Total

= 3 Month Total

- Adjustment/Projected

= Payment/Adjustment

FACILITY/OPERATOR CERTIFICATION

I hereby certify that the information provided in this application is true and correct to the best of my knowledge and belief.

X

Signature of Supervisor/Operator Date - d/m/y

EARLY CHILDHOOD PROGRAM APPROVAL

Cheque Requisition No. (projected only) CR	Date - d/m/y

X

Early Childhood Program Consultant's Signature

NWT4329/0217

Send to Early Childhood Program