



Provider Connection Membership Application and Agreement



Individual Membership | \$30 per year
Child Care Center Membership | \$25 per year per classroom

APPLICANT INFORMATION

INDIVIDUAL MEMBERSHIP

Type of Membership Parent Teacher FCC
Name _____
Address _____
City _____ Zip _____
Email _____ Phone _____
Ages of children you care for _____

CHILD CARE CENTER MEMBERSHIP

Name of Center _____
Director _____
Address _____
City _____ Zip _____
Email _____ Phone _____
Age range of children center cares for _____
Number of Teachers _____ Number of Classrooms _____

TERMS AND CONDITIONS

I (we) agree to assume responsibility for all materials borrowed on this card and to abide by the following rules:

- There will be a \$1.00 fee for replacing lost cards.
- One membership card per classroom must be shared by all the members in that classroom.
- All members are responsible for renewing their membership on time.
- Members must notify The Provider Connection of change of address or telephone.
- Verification of membership may be required before using The Provider Connection's materials and resources.
- Only members are allowed to borrow materials. Materials may not be checked out using someone else's card.
- Most materials may be checked out for two weeks.
- Materials must be returned in original, clean condition.
- Materials not on reserve may be renewed. However, in the interest of equal access to materials, The Provider Connection reserves the right to limit renewals.
- Full replacement cost of damaged materials will be charged to the member.
- Failure to return materials on time may result in added fees and possible restriction of membership privileges.
- Members must read instructions and use materials and equipment properly and safely.
- Center releases The Provider Connection and Palo Alto Community Child Care from any liability for injury to children or adults and damage to property that results from misuse of materials and equipment.

I have read, understood and agree to the above terms and conditions of membership to The Provider Connection.

Applicant's Name

Applicant's Signature

Date

Provider Connection Staff Signature

Date

INTERNAL USE ONLY

Rec'd By: _____ Rec'd On: _____ Payment: \$ _____ Check #: _____ **EXPIRES:** _____

Comments: _____
