Assigned file #

Cowlitz Indian Tribe

Child Care and Development Program

Service Verification Form

(This form is to be completed by the provider or agency)

Client's Name:

Company Information:			
Company Name:		Phone Number:	
Physical Address:	City:	State:	Zip:
Supervisor Name:	Title:		

Work Schedule: Please list the times client is scheduled to attend.							
Days	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Hours Scheduled							
Total Hours Per Week:							

Start Date:

Client Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

For question Please contact CCDP @ Phone (360) 353-9909 • Fax (360) 353-9499 • Email CCDP@cowlitz.org