



VPK Change Notification Form
 Pinellas County Providers

PROVIDER NAME _____
 ADDRESS _____ CITY/STATE _____ ZIP _____

Please select the option(s) that represent the change(s) made and indicate any additional information where requested.

CHANGE OF VPK LEAD TEACHER <small>(A VPK11A Form needs to be attached)</small>	NAME OF NEW LEAD _____		
CLASS ID _____	NAME OF PREVIOUS LEAD _____		
CHANGE OF VPK AIDE <small>(A VPK11A Form needs to be attached)</small>	NAME OF NEW AIDE _____		
CLASS ID _____	NAME OF PREVIOUS AIDE _____		
CHANGE OF DIRECTOR <small>(A VPK10 Form needs to be attached)</small>	NAME OF NEW DIRECTOR _____		
	NAME OF PREVIOUS DIRECTOR _____		
CHANGE ON CONTACT INFORMATION	EMAIL ADDRESS _____		
	PHONE NUMBER _____		
CHANGE OF SUBSTITUTE <small>(A VPK11A Form needs to be attached)</small>	NAME OF NEW SUB _____		
	NAME OF PREVIOUS SUB _____		
ADDITION OF SUBSTITUTE(S) <small>(A VPK11A Form needs to be attached)</small>	NAME(S) _____	_____	_____
	NAME(S) _____	_____	_____
DELETE AN AIDE OR A SUBSTITUTE <small>(Please circle the appropriate one)</small>	NAME _____		
	CLASS ID _____		
NAME OF NEW OWNERSHIP / CORPORATION <small>(copy of the IRS Form SS-4 or 14-C needs to be attached)</small>	NEW NAME _____		
	OLD NAME _____		
CHANGE OF FACILITY NAME OR ADDRESS	NEW NAME OR ADDRESS _____		

CHANGE IN CLASS CAPACITY	CLASS ID _____		
	FROM _____	TO _____	_____
SCHEDULE CHANGE <small>(A VPK11B Form for hours, calendar change, along with Calendar Calculator for all calendar changes needs to be attached)</small>	CLASS ID _____	NEW START DATE _____	_____
	ADD VPK INSTRUCTIONAL DATES _____		
	ADD VPK NON-INSTRUCTIONAL DATES _____		

ADD CLASSROOM - CLASS ID _____ <small>(A VPK11A forms needs to be attached. If changing or adding a new schedule then a VPK11B and possibly a VPK Calendar Calculator needs to be attached)</small>	LEAD TEACHER NAME _____		
	AIDE NAME _____		
	SAME CALENDAR AS _____		
	BEGINNING DATE _____		
	ENDING DATE _____		
CLOSING OF CLASSROOM - CLASS ID _____	LEAD TEACHER NAME _____		
	AIDE NAME _____		
	ENDING DATE _____		

I have examined this application and, to the best of my knowledge and belief, the information provided is true and correct. If any of this information changes, I understand that the provider must submit updated information to the coalition, in writing, within 14 days of the change. I also understand that the provider is encouraged to submit updated information before a change is implemented.

SIGNATURE OF DIRECTOR/OPERATOR/PRINCIPAL OR AUTHORIZED REPRESENTATIVE _____		DATE _____
PRINT NAME & TITLE _____	_____	DATE _____

ELC VPK Staff Only

1 st Request Received by/on: _____	EFS Update _____
1 st Request Completed by/on: _____	People Ware Update _____
2 nd Request Approved by/on: _____	DCF VPK Website Update: _____

Provider Notified on: _____ Portal Email

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