



Berea Early Childhood Regional Training & Parent Resource Center Library Registration Form

PLEASE PRINT ALL INFORMATION

Date: _____

Personal Information

First Name: _____

Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell Phone: _____

Email: _____

District/Agency Information

District/Agency Name: _____

Job Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell Phone: _____

Email: _____

Please complete the following information if you are a college student!

Name of College: _____

Expected Graduation Date: _____

Instructor's Name: _____

Campus Number: _____

Student Email Address: _____

Parent's Name: _____

Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

I understand that check out time is for a period of two weeks and that resources that are not returned may result in the suspension of the use of the facility for my entire District, Agency, or Campus.

Signed

Date

PO Box 159 ♦ 116 Jane Street ♦ Berea, KY 40403
859.986.1929 ♦ 800.343.2959 ♦ Fax: 859.986.9532

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