CHILDCARE SERVICES FOR CSP PARTICIPANT

Sunday _____to Saturday _____

Due Date _____ Time _____

Participant Providing
Childcare Services: _____ Client/Recipient ID:_____
(Print First & Last Name)

Signature of Participant: _____ Required Hours: _____

By signing above, I agree that the information I am providing is true and accurate.

MW! Staff Overseeing the Activity:_____ _____
(Print First & Last Name) (Title)

DATE	ACTUAL HOURS OF PARTICIPATION	SIGNATURE OF INDIVIDUAL PARTICIPATING IN COMMUNITY SERVICE PROGRAM

Total Hours:_____

WR-211 (Revised: 04/01/14)

Equal Opportunity Employer/Service Provider. Michigan Relay Center (800) 649-3777. Auxiliary Aids and Services Available to Individuals with Disabilities.