Provider Request to Terminate Services

VPK Program

(Rev. 10.5.17)

Name: ____

Address: ____

City: ______________________________ State:____________ Zip: _____________

Phone: __________________ Fax: _______________Email: ______________________

Program Year: _________________________________Closure Date:________________

Classroom Identifier: ____

My signature below indicates that 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 I must submit updated information to the Coalition, in writing, within 14 days of the change. I also understand that I am encouraged to submit updated information before a change is implemented as I may be out of compliance with the requirements of the VPK program if the changes are implemented before the Coalition approves of the changes.

________________________________ Printed Name of Owner/Director

________________________________ Signature of Owner/Director

________________________________ Date

Submit Completed form to:
Early Learning Coalition
Family Services
6800 N. Dale Mabry Highway, Suite 158
Tampa, FL 33614
Main Phone: (813) 515-2340
VPK Only Fax: (813) 434-2077

OFFICE USE ONLY:
Date Received: ______________________ Received by: ______________________

Termination Completed? ☐ Yes ☐ No Date Completed: ______________________

Termination Completed By: ____