

COMMUNITY ACTION PROGRAM, INC. OF WESTERN INDIANA EARLY HEAD START — HEAD START MEETING IN-KIND

Meeting _____

Date _____

Site _____

SIGNATURE & PRINTED NAME OF PARENT/VOLUNTEER	CHILD'S NAME OR VOLUNTEER'S ADDRESS	TEACHER HOME VISITOR	HOURS
TOTAL HOURS			

I certify that the above reporting is true and correct.

Signature _____

Title _____

Date _____