



2024-2025 Individual Professional Development Program (IPDP) Application
SUMMER/FALL 2024

DUE DATE: Wednesday, January 8, 2025, there will be NO extensions
This application must be completed in its entirety, with all required signatures along with
OFFICAL Transcript.

1. Name as it appears on your federal income tax return: _____
2. Mailing address: _____
Street or P.O. Box, Apartment or Unit #

City State Zip Phone #
3. Valid email address: _____ **To contact you about your application status*
4. Your birth month and day: ____/____ (mm/dd) **Your birth year is not needed.*
5. **Education** (please check 1 and specify):
____ I have not yet declared my major.
____ I have officially declared my major as _____
____ I am pursuing a certificate, diploma, or degree. Please specify: _____

6. **SUBSTITUTE for IRS FORM W-9**

By signing below, I certify that under penalties of perjury:

1. My Individual Taxpayer Identification Number (TIN) is correct,
2. I am not subject to backup withholding* due to failure to report interest and dividend income, and
3. I am a U.S. person.

*If the IRS has notified you that backup withholding applies, then you must strike out the language in the above certification that related to underreporting.

Signature (Required) Social Security Number Date

7. **By signing below**, I understand that I am applying to participate in the IPDP activity, agree to all terms and conditions and certify that all statements have been accurately completed, and that official college documents have been provided as required.

Applicant Signature (Required) Date

8. **TO BE COMPLETED AND SIGNED by Director, Owner or Principal** – Verification of applicant employment:

- Applicant is employed as: _____
Job Position
- Applicant has worked at least 30 hours per week with children ages birth to 5 for at least 6 of the previous 9 months in licensed ECE facilities in Lincoln or Gaston Counties:

_____ Yes _____ No
- If no, and applicant has been on leave, please indicate reason and dates below:

_____ Maternity leave _____ Illness _____ Other (please specify): _____

Leave dates were from ____/____/____ (mm/dd/yyyy) through ____/____/____ (mm/dd/yyyy)

Authorized signature: _____
Name and Title (Director, Owner, or Principal) Date

Name of Child Care Facility or Program DCDEE State License #

Application Checklist – Required items for applications to be considered for payment

___ Application completed in its entirety with ALL required signatures

___ Official transcript with courses and declared major as applicable

___ Please ensure your application and official transcript are received by the due date of **Wednesday, January 8, 2025**. They may be dropped off in person, mailed, or sent by email to Carolyn Payne at the address below:

The Partnership for Children of Lincoln & Gaston Counties, Inc.

Attention: Carolyn Payne, ncpk@pfclg.org
120 Roechling Street, Dallas, NC 28034
(704) 922-0900 EXT 109

This Space is for PFCLG Staff Use Only

➤ Eligible ___Yes ___No
➤ If Yes:
 ___ # of qualifying semester hours
 \$_____ Amount being paid

Processed By: _____ Date _____

Monitored By: _____ Date _____

Date Stamp