North Country Community Mental Health

PROOF OF TRAINING FORM

CLIENT NAME	CASE NUMBER	MEDICAID ID
HOME/DAY PROGRAM/AGENCY	DOB	GENDER

Trainee	Date Trained

Trainer Acknowledgement: I acknowledge that I have trained the individual listed above on the implementation of the

Check Here	Name of Document	Effective Date
	IPOS	
	Addendum/Review (where changes were made that impact the role of the provider)	
	Care Plan	
	Other:	

The trainee(s) listed above can now train others on the above marked documents.

____

Trainer Signature

Trainee Acknowledgement: I acknowledge that I have been trained and will now train others on these documents. I understand I must keep a copy of this form and the information contained in it safe, confidential, and readily available for inspection.

Signature	Effective Date