TRAINING VERIFICATION

CERTIFICATION OF SPECIAL NEEDS TRAINING

To be completed by the Individual's Family or Primary Support Person:

Individual's Name: _____

Individuals Address: _____

Street City State Zip Code

Individual's County of Residence: _____

Identify any special needs the provider will need to know (if none exist, please write N/A):

_____

_____

_____

Signature of Family/Primary Support Person**:** Date:

_____ _____

My signature below verifies that I, the Provider, have received all applicable training from the above named Individual's family/primary support person as to the special needs identified (if any.

Provider's Signature: _____ Date: _____

Print Name:_____