Macomb-Oakland Regional Center, Inc.

INSERVICE/TRAINING RECORD

Individual Name: MRN: Home Name:	DATE	TIME (Ex. 1:00 p.m. – 2:15 p.m.)

INDIVIDUALS ATTENDING

PRINT FULL NAME	**PRINT** JOB TITLE/CREDENTIALS
Name of person responsible to train those not in attendance*: 1.	
2.	
3.	
4.	
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15.	

TOPIC:

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* CLS/Respite Provider or their designee is responsible to assure that all caregivers implementing the plan are trained.
* CLS/Respite Provider or their designee is responsible to notify the SC when the retraining is necessary.

SIGNATURE OF TRAINER	JOB TITLE/CREDENTIALS

DISTRIBUTION of COPIES:

- ☐ Provider
- ☐ Health Information Management
- ☐ OTHERS _____

(REV. 10 - 15)