

**LISTING OF TRAININGS COMPLETED BY INSTITUTION STAFF, RESIDENTS, EMPLOYEES,
SUBSTITUTES, ALTERNATES, AND VOLUNTEERS**

FACILITY: _____

DATE: _____

FACILITY ADDRESS: _____

INITIAL TRAINING COURSES (DUE WITHIN 90DAYS)

(DUE WITHIN 30 DAYS)

CONTINUING TRAINING

GENERAL INFORMATION	DATE PRINTS EXPIRE:	C & R * √	L E T T E R ** √	ORIENTATION DATE	TB EXPIRES (2 YRS FROM DATE TAKEN)	CPR EXPIRES	FIRST AID Taken	SIGNS OF ILLNESS (2hrs)	CHILD ABUSE & NEGLECT (2hrs)	SIDS	HUMAN GROWTH AND DEVELOPMENT OR POSITIVE GUIDANCE (3 hours)	RESTRAINT TRAINING TAKEN (renewed annually)	POLICIES AND PROCEDURES TAKEN (renewed annually)	CHILD WELLNESS*** (2 hours required annually)	DATE, REGISTRY #, TRAINING HOURS *** Facility Licensing year
				WRITTEN EVIDENCE				BLOOD-BORNE PATHOGENS							
NAME: PHONE: TITLE: Hire Date: Start Date: # Hours/week:				_____											
NAME: PHONE: TITLE: Hire Date: Start Date: # Hours/week:				_____											
NAME: PHONE: TITLE: Hire Date: Start Date: # Hours/week:				_____											
NAME: PHONE: TITLE: Hire Date: Start Date: # Hours/week:				_____											

PLEASE USE MONTH/DATE/YEAR IN EACH OF THE ABOVE COLUMNS; A CHECKMARK IS NOT SUFFICIENT

* Consent and Release Form ** Clearance Letter from Child Care Licensing *** Child Wellness-Healthy Nutrition/Obesity Prevention/Physical Activity

REMINDER: CPR only counts as three hours; First Aid and Symptoms of Illness may be counted toward the annual training once every 36 months.

NOTE: MUST HAVE NEGATIVE TB TEST, FINGERPRINT PROCESS STARTED, AND ALL REQUIRED TRAINING TO COUNT IN RATIO.