Health Certification Project
TRAINING VERIFICATION FORM

CANDIDATE INFORMATION

Name _____ Social Security Number _____

TRAINING INFORMATION

Please indicate with a "X" in the type of training completed.

	Long Term Care (LTC) (75 hr. minimum)		Developmentally Disabled Care (75 hr. minimum)		Residential Care (45 hr. minimum)
	Home Health Care (HHC) (75 hr. minimum)		Deeming – LTC to HHC (16 hours minimum)		Adult Day Care (45 hr. minimum)

Training Facility Name: _____

Training Facility Address: _____

Training Completion Date: _____ Training Facility Code: _____

_____ _____

Instructor's Name (Please print clearly) Instructor's Signature

TRAINING VERIFICATION STATEMENT

I verify that the above named candidate has successfully completed the minimum number of training hours and all required performance checklists for program indicated above. Furthermore, this training was provided through a program approved by the Oklahoma State Department of Health. **(Note for Long-Term Care Aide and Home Care Aide Training programs: This form must be signed by the R.N. who is listed on the NATCEP application as the R.N. Training Supervisor. LPN's cannot be Training Supervisors for LTC or HHC aide training programs and may not sign this form.)**

RN LPN QIDP Other

_____ _____

Training Supervisor's Name (Please print clearly) Training Supervisor's Signature

_____ _____

Training Supervisor's Telephone Number Date

CLINICAL SKILLS EXAMINATION RECORD

The Test Site Coordinator must sign and date this form after scoring each skill in the clinical skills test packet. **Candidates that do not pass the clinical skills examination after three attempts must retrain and repeat the testing process.**

Exam 1: CSO # _____ Form: ____ _____ Date _____ Pass/Fail
Test Site Coordinator Signature

Exam 2: CSO # _____ Form: ____ _____ Date _____ Pass/Fail
Test Site Coordinator Signature

Exam 3: CSO # _____ Form: ____ _____ Date _____ Pass/Fail
Test Site Coordinator Signature

WRITTEN COMPETENCY EXAMINATION RECORD

The Test Site Coordinator must sign and date this form at each written competency test administration. **Candidates that do not pass the written competency examination after three attempts must retrain and repeat the testing process.**

Written Exam 1 _____ Date _____ Pass/Fail
Test Site Coordinator Signature

Written Exam 2 _____ Date _____ Pass/Fail
Test Site Coordinator Signature

Written Exam 3 _____ Date _____ Pass/Fail
Test Site Coordinator Signature

NOTE: All testing must be completed within three years of completion of training.

Revised January 16, 2020