WEST BERGEN MENTAL HEALTHCARE

TRAINING ATTENDANCE

*Date of Training:*_____

Program(s): _____

CEU credits (if applicable): _____

Targeted Skills: _____

Topic/Title: _____

Length of Training in hours: _____

Location of Training: _____

Presenter: _____

Presenter Credentials:_____

Brief description of presentation:

Also attach any flyer or brochure.

_____

_____

My signature below indicates my participation / training as stated above:

_____
Signature

_____
Printed Name

_____
Date

Rev: 2008, 3/2012