Foster Parent Name __________________________________________ Date ____________

BOOK or ARTICLE - Title: __________________________________________

Author: ___________________________________________________________

# Pages Read (check): ___ 50 ___51-100 ___101-150 ___151-200 ___201-250 ___251-300 Other ______

VIDEO or WEBINAR: Title: __________________________________________

Producer or Agency or Author: ______________________________________

# Minutes (check): ____ up to 30 _____31-60 _____61-90 _____91-120 Other ______________

WORKSHOP or CONFERENCE Title: _________________________________

Date: ______________________

Wkshop/Conf Activities (Can Attach Agenda): __________________________

# Minutes (check): ____ up to 30 _____31-60 _____61-90 _____91-120 Other ______________

SUPPORT GROUP: Name & Location: _________________________________

Date: ______________________

Presentation Title: _______________________________________________

# Minutes (check): ____ up to 30 _____31-60 _____61-90 _____91-120 Other ______________

PEER MEETINGS: Mentoring, Advisory Committees, Associations, Other ______________________

Date: ______________________

Meeting Name and Activities: _______________________________________

# Minutes (check): ____ up to 30 _____31-60 _____61-90 _____91-120 Other ______________

PARENT SKILLS TRAINING: Sooner Start Family Training, TBRI, PCI, CPR, Other ______________________

Date: ______________________ Trainer’s Signature: ______________________

Training Activities: ________________________________________________

# Minutes (check): ____ up to 30 _____31-60 _____61-90 _____91-120 Other ______________

MEDICAL/DEVELOPMENTAL CARE SKILLS TRAINING (SEE TRAINER’S SIGNATURE LINE): Diabetes Education & Treatment; Occupational Therapy, Use of Specialized Equipment, Other ______________________

Training Subject/Activities: _________________________________________

Trainor’s Name and Credentials: _____________________________________

TRAINER’S SIGNATURE: ____________________________________________

# Minutes (check): ____ up to 30 _____31-60 _____61-90 _____91-120 Other ______________
DHS CARE PROVIDER IN SERVICE TRAINING VERIFICATION
All trainings are subject to worker/supervisor approval. If in doubt, check with your worker before attending training.

1. In 2-3 sentences, briefly summarize the topic and what you learned.

2. How will you use this information in your work with children and youth?

3. Would you recommend this In Service experience to other families?
   Yes, because ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

   No, because ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________