

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.

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: _____
Wkshp/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: _____
Trainer's Name and Credentials: _____
TRAINER'S SIGNATURE: _____
Minutes (check): ___ up to 30 ___ 31-60 ___ 61-90 ___ 91-120 Other _____

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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 _____

