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.

<table>
<thead>
<tr>
<th>Training Facility Name:</th>
<th>Training Completion Date:</th>
<th>Training Facility Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term Care (LTC) (75 hr. minimum)</td>
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<tr>
<td>Developmentally Disabled Care (75 hr. minimum)</td>
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<tr>
<td>Residential Care (45 hr. minimum)</td>
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<tr>
<td>Home Health Care (HHC) (75 hr. minimum)</td>
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<tr>
<td>Deeming – LTC to HHC (16 hours minimum)</td>
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<tr>
<td>Adult Day Care (45 hr. minimum)</td>
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</tbody>
</table>

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.)

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