Health Certification Project
TRAINING VERIFICATION FORM – Supportive Home Assistant

CANDIDATE INFORMATION

Name _____

TRAINING INFORMATION

Training Facility Name: _____

Training Facility Address: _____

Training Completion Date: _____

_____ _____

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 skills testing through the Supportive Home Assistant program indicated above. I further attest that documentation of this candidate's training and skills testing is available for review upon request by the Oklahoma State Department of Health.

RN
LPN

_____ _____

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

_____ _____

Training Supervisor's Telephone Number Date

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: Documentation of the candidate's training and written exam result must be retained by the candidate's employer in the candidate's personnel file.

Revised August 21, 2017