Annual Provider Training Confirmation for SD
AuSable Valley Community Mental Health Authority

My signature below acknowledges I have completed all required trainings listed herein. Additionally, I understand that this completed form must be returned to the Employer and/or FI within 30 days in order to receive payment.

All trainings must be completed annually with proof submitted to the Employer and/or FI for audit purposes.

Name (please print) _____

My signature below indicates:	Date completed and employee initials
I have read the First Aid reference guide on basic First Aid and I feel I could perform basic First Aid if needed.	_____ (within 30 days of hire and annually thereafter)
I have completed Blood Borne Pathogens training and I feel I am knowledgeable about Blood Borne Pathogens.	_____ (within 10 days of hire and annually thereafter)
I have completed Recipient Rights training and I know how to file a complaint if needed.	_____ (within 30 days of hire and annually thereafter)
I have completed HIPAA and Corporate Compliance training and I agree to work within the regulations established by the Michigan Department of Health and Human Services and the Michigan Mental Health Code.	_____ (within 30 days of hire and annually thereafter)

If you would like to attend AuSable Valley trainings, please contact the Agency Trainer at
Phone: (989) 345-5571.
Please provide your full name, phone number, valid email and name of training requested.

_____
Employee Signature & Date

Revised March 2020