Community Mental Health for Central Michigan

Individual Plan of Service/Addendum Training Record

Consumer Name: _____ DOB: _____ Case #: _____

Provider Agency: _____

Effective Date of IPOS/Addendum: _____

Trainer's Name: _____
Print Name *Signature* *Credentials/Title*

Date of IPOS/Addendum Training: _____

The following staff have been trained on the Individual Plan of Service/Addendum.

Name of Staff Attending *(please print)*	**Name of Staff Attending** *(please print)*