

**LISTING OF TRAININGS COMPLETED BY FACILITY AND FAMILY/GROUP CARE STAFF, RESIDENTS, EMPLOYEES, SUBSTITUTES, ALTERNATES, AND VOLUNTEERS**

FACILITY: \_\_\_\_\_  
 FACILITY ADDRESS: \_\_\_\_\_

DATE: \_\_\_\_\_

GENERAL INFORMATION	DATE PRINTS EXPIRE:	C & R * √	L E T T E R ** √	ORIENTATION DATE	NEVADA REGISTRY ID #	TB EXPIRES (2 YRS FROM DATE TAKEN)	CPR EXPIRES	FIRST AID Taken	SIGNS OF ILLNESS (2hrs)	CHILD ABUSE & NEGLECT (2hrs)	SIDS (2hrs)	HUMAN GROWTH AND DEVELOPMENT OR POSITIVE GUIDANCE (3 hours)	DATE, REGISTRY #, TRAINING HOURS	CHILD WELLNESS*** (2 hours required annually)
				WRITTEN EVIDENCE	EXP. DATE	*** Facility Licensing year								
1. NAME:  PHONE: TITLE: Hire Date: Start Date: # Hours/week:					_____									
2. NAME:  PHONE: TITLE: Hire Date: Start Date: # Hours/week:					_____									
3. NAME:  PHONE: TITLE: Hire Date: Start Date: # Hours/week:					_____									
4. NAME:  PHONE: TITLE: Hire Date: Start Date: # Hours/week:					_____									

PLEASE USE MONTH/DATE/YEAR IN EACH OF THE ABOVE COLUMNS; A CHECKMARK IS NOT SUFFICIENT

\* Consent and Release Form    \*\* Clearance Letter from Child Care Licensing    \*\*\* Child Wellness-Healthy Nutrition/Obesity Prevention/Physical Activity  
 REMINDER: CPR only counts as three hours; First Aid and Symptoms of Illness may be counted toward the annual training once every 36 months.

NOTE: MUST HAVE NEGATIVE TB TEST, FINGERPRINT PROCESS STARTED, AND ALL REQUIRED TRAINING TO COUNT IN RATIO.  
 (Revised 12-14)