Attestation of Community Health Worker Training Program Completion

Form A

Part 1-General Information-Please Print

(Applicant must complete this part and send to the community health worker training program)

Legal Name_____
Last First Middle Maiden

Date of Birth_____Telephone Number_____
Month/Day/Year

Email Address_____

Signature_____Date_____

Part 2-Attestation of Completion of Community Health Worker Training Program-Please Print

(Community health worker training program representative must complete this part and send directly to the Board)

Program Name_____

Address_____

City_____State_____Zip_____

Telephone Number of Program_____

This is to verify that the applicant named above has successfully completed the above named community health worker training program and is competent to provide care as a community health worker.

_____
Completion Date (Month/Day/Year)

_____ _____
Name of Training Program Administrator (Print) Title of Training Program Administrator (Print)

_____ _____
Telephone Number of Training Program Administrator E-mail Address of Training Program Administrator

_____ _____
Signature of Training Program Administrator Date

The Training Program Administrator may submit this completed form by email to chw@nursing.ohio.gov or by Fax to (614) 466-0388 or mail "Attention CHW" to the address above.