Name of Person Being Trained
TRAINERS FILL IN TRAINEES NAME. DO NOT HAND OUT WITHOUT COMPLETING THIS BOX

Ohio Department of Job and Family Services

HEALTH TRAINING DOCUMENTATION FOR CHILD CARE

FIRST AID FOR CHILD CARE

Date(s) of Training	Hours of Training	Expiration Date
	☐ Full Course _____ Hours ☐ Review Course _____ Hours ☐ Other _____ Hours	

(Check one)

☐ Licensed Physician ☐ Emergency Medical Service Instructor ☐ Registered Nurse

☐ Authorized Trainer for a health organization approved by ODJFS - Agency Name: ______________________________

I verify that I have followed a curriculum approved by ODJFS. I certify that the information on this form is true and accurate.

Signature of Trainer	Trainer's Email Address *(Optional)*	Date

Name and Address of Trainer (*please print*)	Telephone Number	**CHILD CARE LICENSING USE ONLY** Date Reviewed: ______________ CCLS Initials: ______________

CPR

Date(s) of Training	Hours of Training	Expiration Date

☐ Authorized Trainer for a health organization approved by ODJFS - Agency Name: ______________________________

Type of Training *(Check as many as applicable to training provided)*: ☐ Infant ☐ Child ☐ Adult

I certify that the information on this form is true and accurate.

Signature of Trainer	Trainer's Email Address *(optional)*	Date

Name and Address of Trainer *(please print)*	Telephone Number	**CHILD CARE LICENSING USE ONLY** Date Reviewed: ______________ CCLS Initials: ______________

COMMUNICABLE DISEASE FOR CHILD CARE

Date(s) of Training	Hours of Training	Expiration Date
	☐ Full Course 6 Hours ☐ Review Course 3 Hours ☐ If more than 6 hours _____	

(Check one)

☐ Licensed Physician

☐ Registered Nurse

☐ Authorized Communicable Disease Trainer for an approved health organization
Agency Name: ______________________________

I verify that I have followed a curriculum approved by ODJFS. I certify that the information on this form is true and accurate.

Signature of Trainer	Trainer's Email Address *(optional)*	Date

Name and Address of Trainer *(please print)*	Telephone Number	**CHILD CARE LICENSING USE ONLY** Date Reviewed: ______________ CCLS Initials: ______________

CHILD ABUSE PREVENTION

Date(s) of Training	Hours of Training	Expiration Date
	☐ Full Course 6 Hours ☐ Refresher Course 3 Hours ☐ Other Hours _____ *(if more than 6)*	

Trainer Qualifications *(check one)*

☐ Authorized trainer for a PCSA

☐ An associate's degree (or higher) in an approved field with 2 years of experience assessing child abuse and neglect or providing training in child abuse prevention

☐ Licensed physician or registered nurse with 2 years of experience professionally assessing child abuse and neglect or providing counseling to abuse children or training others in child abuse prevention or a combination of experience and training.

I verify that I have followed the curriculum required in 5101:2-12-10, 5101:2-13-10 or 5101:2-14-03 of the Ohio Administrative Code.
I certify that the information on this form is true and accurate.

Signature of Trainer	Trainer's Email Address *(optional)*	Date

Name and Address of Trainer *(please print)*	Telephone Number	**CHILD CARE LICENSING USE ONLY** Date Reviewed: ______________ CCLS Initials: ______________