

SBIRT Training (Screening, Brief Intervention and Referral to Treatment) For Partnership HealthPlan of California

			CHECK ONE	
Employee Name	Job Function/Title	Date of	Expanded	Brief
		Training	Screening	Intervention

Attestation:

By signing this document, I am attesting that the individuals listed above have participated in the training listed above for the Screening, Brief Intervention and Referral to Treatment program. They understand the content of the training, and agree to abide by all applicable policies and procedures.

Practice Name:

Billing NPI(s):

Print name (Medical Director or Senior Physician)

Signature

Date

Please keep this form in a designated location that is easily accessible and be ready to share it with PHC or DHCS staff who request training information during their visits.