Seniors and Persons with Disabilities Training (SPD)
Partnership HealthPlan of California

Employee Name	Job Function/Title	Date

Attestation:

By signing this document, I am attesting that the individuals listed above participated in the SPD Sensitivity Training. 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) **Date**

_____

Signature

Click Here to Send

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.