Seniors and Persons with Disabilities Sensitivity Training

Employee Name	Job Function/Title	Date

Attestation:

By signing this document, I am attesting that the individuals listed above participated in the Seniors and Persons with Disabilities 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

Submit form here

Please keep this form in a designated location that is easily accessible and be ready to share it with Partnership or the Department Health Care of Services staff who request training information during their visits.