

Name of Person being Trained:
**TRAINERS FILL IN TRAINEES NAME. DO NOT
 HANDOUT WITHOUT COMPLETING THIS BOX**

Ohio Department of Job and Family Services
**INSERVICE TRAINING FOR TYPE B HOME AND
 IN-HOME AIDE CHILD CARE PROVIDERS**

FIRST AID	Date(s) of Training	Hours of Training <input type="checkbox"/> Full Course ____ Hours <input type="checkbox"/> Review Course ____ Hours <input type="checkbox"/> Other ____ Hours	Expiration Date
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Check one:
 Licensed Physician Emergency Medical Service Instructor Register 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		Date
Please Print: Name and Address of Trainer	Telephone Number	CDJFS USE ONLY Date Reviewed: CDJFS Initials:

CPR	Date(s) of Training	Hours of Training	Expiration Date
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Authorized Trainer for a health organization approved by ODJFS Agency Name _____
 Type of Training: Infant Child Adult

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

Signature of Trainer		Date
Please Print: Name and Address of Trainer	Telephone Number	CDJFS USE ONLY Date Reviewed: CDJFS Initials:

HEALTH AND SAFETY	Date(s) of Training	Hours of Training	Training Subject
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Health and Safety in Family Child Care Course
 Approved by the Ohio Department of Job and Family Services

Trainer Qualifications (check one):

- Current County Department of Job and Family Services employee.
- At least one year experience in subject area of the training AND 18 quarter hours or 12 semester hours from an accredited university, college or technical college in subject area.
- At least one year experience in subject area of the training AND a currently valid CDA OR a preprimary credential from the AMS or AML.
- A licensed physician or registered nurse.

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

Signature of Trainer		Date
Please Print: Name and Address of Trainer	Telephone Number	CDJFS USE ONLY Date Reviewed: CDJFS Initials:

NAME OF PERSON BEING TRAINED TRAINERS FILL IN TRAINEES NAME. DO NOT HANDOUT WITHOUT COMPLETING THIS BOX	Hours of Training	Date(s) of Training
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COMMUNICABLE DISEASE	Date(s) of Training	Hours of Training <input type="checkbox"/> Full Course 6 Hours <input type="checkbox"/> Other ____ Hours <input type="checkbox"/> Review Course 3 Hours	Expiration Date
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Check one:
 Licensed Physician Authorized Trainer for a health organization approved by ODJFS
 Register Nurse 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	Date
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Please Print: Name and Address of Trainer	Telephone Number	CDJFS USE ONLY Date Reviewed: CDJFS Initials:
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CHILD ABUSE PREVENTION	Date(s) of Training	Hours of Training <input type="checkbox"/> Full Course 6 Hours <input type="checkbox"/> Other ____ Hours <input type="checkbox"/> Review Course 3 Hours	Expiration Date
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TRAINER QUALIFICATIONS (check one)
 Authorized Trainer for a health organization approved by ODJFS
 At least an Associates Degree in social work, child development or related field from an accredited collage AND two years experience in professionally assessing child abuse and neglect or providing counseling to abused children or training others in child abuse prevention or a combination of experience and training.
 A licensed physician or registered nurse AND two years experience professionally assessing child abuse and neglect or providing counseling to abused children or training others in child abuse prevention or a combination of experience and training

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

Signature of Trainer	Date
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Please Print: Name and Address of Trainer	Telephone Number	CDJFS USE ONLY Date Reviewed: CDJFS Initials:
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<input type="checkbox"/>	CHILD GROWTH & DEVELOPMENT	OR	<input type="checkbox"/>	GENERAL KNOWLEDGE FOR CHILD CARE
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Check applicable box for appropriate training category

Description of Training _____ _____
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Trainer Qualifications (check all that apply):
 At least two years experience specific to the training subject area,
AND
 90 quarter hours or 60 semester hours from an accredited university, college or technical college with 36 quarter or 24 semester hours in child development.
 A currently valid child development associate credential (CDA).
 A preprimary credential from the American Montessori Society (AMS) or the Association Montessori International (AMI).
 A licensed physician or registered nurse.

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

Signature of Trainer	Date
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Please Print: Name and Address of Trainer	Telephone Number	CDJFS USE ONLY Date Reviewed: CDJFS Initials:
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Was this electronic media training? Yes No

Provider's Signature verifying attendance	Date
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