Department of State Health Services

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DSHS Use Only:

Reviewed By:

Approved Date: **CITY:**

PROGRAM OPERATOR if different from above:		PHONE:
PHYSICAL ADDRESS of location where program will be held, if different from above:		ZIP CODE:
CITY:	COUNTY:	COUNTY ID#:
DATES OF OPERATION:		

Employee Name	Date Employed	Training Course Name	Course Approval #	Date Training Completed