**ATTACHMENT B**

**Staff Training Verification**

Developmental Center:

Provider Administrator Name:

Provider Agency Name:

Name of Staff Trained:

Individual(s):

Anticipated move date out of the developmental center:

List dates and specific times of training:

I attest that the information above is accurate and reflects actual on-site training of provider staff with individuals listed above.

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Administrator or Designee Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Developmental Center Superintendent or Designee Date

NOTE: Limited to $500 per individual; effective September 1, 2015

DORR – System Innovation Fund Verification, July 28, 2015