St. Clair County Community Mental Health Authority

Individual Plan of Service (IPOS) Training Log

Individual:_____ Case #: _____

Plan Effective Date: _____ Plan Expires On:_____

(Check Here) ☐ IPOS ☐ Amendment ☐ Periodic Review (If Changes Occurred): _____

Content of Training: Goal #_____, Goal #_____, Goal #_____, Objective(s): _____, _____, _____

Specific Area of Review: _____

If OT, RN, or Clinical Goals were written in the IPOS, Professional Staff **MUST** provide Training.

Section #1

To be completed by <u>CMH Staff</u> while training on the IPOS, Amendment or PR.

Training Provided by: _____

(Printed Name, Credentials, Job Title of Trainer, & Program/Location Affiliated With)

To: _____ on _____

(Printed Name, Credentials, Job Title of Trainee, & Organization/Program Affiliated With) Training Date: (MM/DD/YYYY)

*****For Training of MULTIPLE Staff – Use Section #3*****

_____ on _____

Signature of Trainee Training Date: (MM/DD/YYYY)

Section #2

Trainee is now <u>CERTIFIED to TRAIN staff</u> on the Individual Plan of Service, Amendment or PR.

I,_____ on _____

(Printed Name, Credentials, Job Title of Trainer, & Organization/Program Affiliated With) Training Date: (MM/DD/YYYY)

To: _____

(Printed Name, Credentials, Job Title of ***Individual Being Trained***, & Organization/Program Affiliated With)

*****For Training of MULTIPLE Staff/Individuals – Use Section #3*****

_____ on _____

Signature of Individual Trained Training Date: (MM/DD/YYYY)

Section #3

*****Printed Name & Job Title***** For Training of Multiple Staff: Group Homes, ACT, CIS, etc.	**Organization/Program Affiliated With**	**Signature and Date of Training Date**