

ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

# CCBHC INFORMATIONAL TRAINING FOR DCOs

## Training Attestation

Name (please print): \_\_\_\_\_

Agency/Program: \_\_\_\_\_

My signature below indicates that I have reviewed the St. Clair County Community Mental Health **CCBHC Informational Training for DCOs** self-study training and I have achieved functional competency in the training subject matter. I also understand that if I have any questions regarding the training subject matter, I may contact the St. Clair County Community Mental Health Training Department for clarification.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Upon completion, please forward this training attestation and answer sheet to your organization's human resources/training representative.



3111 Electric Avenue  
Port Huron, MI 48060  
Phone: 810-985-8900