ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

DISASTER PLANNING/CONTINUITY OF OPERATIONS

Training Attestation

Name (please print): _____

Agency/Program: _____

My signature below indicates that I have reviewed the St. Clair County Community Mental Health Disaster Planning/Continuity of Operations (Business Resumption Plan) 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:** _____

Trainer and/or Grader Name (please print): _____

Trainer and/or Grader 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