ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH

# MEDICATION TRAINING ATTESTATION

Name (please print): _____

Agency Affiliation/Job Title: _____

My signature below indicates that (check all):

☐ I have reviewed the Seizure Types and Procedure for Administration handouts on _____/_____/_____.

☐ I have reviewed the Medication training Powerpoint on _____/_____/_____.

Signature: _____ Date: _____

Please give this completed Attestation to the SCCCMH training representative upon entering the face to face portion of Medication training. You will not be permitted to attend Medication training at SCCCMH without this documentation.

Thank you.

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