Name of Person being Trained:
TRAINERS FILL IN TRAINEES NAME. DO NOT HANDOUT WITHOUT COMPLETING THIS BOX

Ohio Department of Job and Family Services

INSERVICE TRAINING FOR CHILD CARE EMPLOYEES CHILD CARE CENTERS AND TYPE A HOMES

FIRST AID

Date(s) of Training	**Hours of Training**	**Expiration Date**
	☐ Full Course ____ Hours ☐ Review Course ____ Hours ☐ Other ____ Hours	

Check one:

☐ Licensed Physician ☐ Emergency Medical Service Instructor ☐ Register Nurse

☐ Authorized Trainer for a health organization approved by ODJFS Agency Name: ______________________________

I verify that I have followed a curriculum approved by ODJFS. I certify that the information on this form is true and accurate.

Signature of Trainer		**Date**
Please Print: Name and Address of Trainer	Telephone Number	**CHILD CARE LICENSING USE ONLY** Date Reviewed: CCLS Initials:

CPR

Date(s) of Training	Hours of Training	**Expiration Date**

☐ Authorized Trainer for a health organization approved by ODJFS Agency Name ______________________________

Type of Training: ☐ Infant ☐ Child ☐ Adult

I certify that the information on this form is true and accurate.

Signature of Trainer		Date
Please Print: Name and Address of Trainer	Telephone Number	**CHILD CARE LICENSING USE ONLY** Date Reviewed: CCLS Initials:

COMMUNICABLE DISEASE

Date(s) of Training	**Hours of Training**	**Expiration Date**
	☐ Full Course 6 Hours ☐ Other ____ Hours ☐ Review Course 3 Hours	

Check one:

☐ Licensed Physician ☐ Emergency Medical Service Instructor ☐ Authorized Trainer for a health organization approved by ODJFS

☐ Register Nurse Agency Name: ______________________________

I verify that I have followed a curriculum approved by ODJFS. I certify that the information on this form is true and accurate.

Signature of Trainer		**Date**
Please Print: Name and Address of Trainer	Telephone Number	**CHILD CARE LICENSING USE ONLY** Date Reviewed: CCLS Initials:

CHILD ABUSE PREVENTION

Date(s) of Training	**Hours of Training**	**Expiration Date**
	☐ Full Course 6 Hours ☐ Other ____ Hours ☐ Review Course 3 Hours	

TRAINER QUALIFICATIONS (check one)

☐ Authorized Trainer for a health organization approved by ODJFS

☐ At least an Associates Degree in social work, child development or related field from an accredited collage AND two years experience in professionally assessing child abuse and neglect or providing counseling to abused children or training others in child abuse prevention or a combination of experience and training.

☐ A licensed physician or registered nurse AND two years experience professionally assessing child abuse and neglect or providing counseling to abused children or training others in child abuse prevention or a combination of experience and training

I certify that the information on this form is true and accurate.

Signature of Trainer		**Date**
Please Print: Name and Address of Trainer	Telephone Number	**CHILD CARE LICENSING USE ONLY** Date Reviewed: ____________ CCLS Initials:

NAME OF PERSON BEING TRAINED
TRAINERS FILL IN TRAINEES NAME. DO NOT HANDOUT WITHOUT COMPLETING THIS BOX

Ohio Department of Job and Family Services
INSERVICE TRAINING FOR CHILD CARE EMPLOYEES
CHILD CARE CENTERS AND TYPE A HOMES

CHILD DEVELOPMENT	Date(s) of Training	Hours of Training	Training Subject

Description of Training ____
____
____

Trainer Qualifications (check one):

- ☐ Master's degree or higher in child development or related field.
- ☐ At least two years experience in subject area of the training AND 90 quarter hours or 60 semester hours from an accredited university, college or technical college with 36 quarter or 24 semester hours in child development.
- ☐ At least two years experience in subject area of the training AND a currently valid child development associate credential (CDA).
- ☐ A licensed physician or registered nurse AND two years experience in subject area.

I certify that the information on this form is true and accurate.

Signature of Trainer		Date
Please Print: Name and Address of Trainer	Telephone Number	**CHILD CARE LICENSING USE ONLY** Date Reviewed:______________ CCLS Initials:

Was this electronic media training? ☐ Yes ☐ No

Administrator's Signature verifying trainee attendance	Date

HEALTH AND SAFETY	Date(s) of Training	Hours of Training	Training Subject

Descriptions of Training: ____
____
____

Trainer Qualifications (check one):

- ☐ Master's degree or higher in related field.
- ☐ At least two years experience in subject area of the training AND 36 quarter hours or 24 semester hours from an accredited university, college or technical college in subject area.
- ☐ At least two years experience in subject area of the training AND a currently valid certification or licensure in the subject area.
- ☐ A licensed physician or registered nurse AND two years experience in subject area.

I certify that the information on this form is true and accurate.

Signature of Trainer		Date
Please Print: Name and Address of Trainer	Telephone Number	**CHILD CARE LICENSING USE ONLY** Date Reviewed:______________ CCLS Initials:

Was this electronic media training? ☐ Yes ☐ No

Administrator's Signature, verifying trainee attendance	Date