

Annual Provider Training Confirmation for SD Wellvance

Training	Compliance Due Date	Completed Date
CPR and First Aid Training (DCW)	Within 30 days of hire and bi-annually	
Corporate and Regulatory Compliance	Within 30 days of hire and annually	
Blood Borne Pathogens/Infection Control	Within 30 days of hire and annually	
HIPAA Privacy and Security	Within 30 days of hire and annually	
Recipient Rights	Within 30 days of hire and annually	

My signature below acknowledges I have completed all required trainings listed herein. Additionally, I understand that this completed form must be returned to the Employer and/or FI within 30 days in order to receive payment.

My signature confirms I feel I could perform basic First Aid if needed. I feel I am knowledgeable about Blood Borne Pathogens. I know how to file a complaint if needed. I agree to work within the regulations established by the Michigan Department of Health and Human Services and the Michigan Mental Health Code.

All trainings must be completed annually with proof submitted to the Employer and/or FI for audit purposes.

Printed Name: _____

Employee Signature: _____

Hire Date: _____

Date: _____

Organization: _____

You may use the free website: <https://improvingmipractices.org> or any other Medicaid approved training sites.

Please note verification of listed trainings may be requested for annual site audits.

Please contact Wellvance with any questions.

Respectfully,

Julie Streeter
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