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Original copy to Survey Team Lead & Copy to Provider Representative:

***Agency Representative Name/Signature, Title & Date Received:** _____

Training Evidence Must be provided to Survey Team by: DATE: _____ TIME: _____

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Page ____ of ____

| <u>Agency Personnel and Title</u> | <u>DOH</u> | <u>EAR</u> 1A26 A26.1 (CoP) | <u>CCHS</u> 1A25 A25.1 (CoP) | <u>IST</u> 1A37 (CoP) | <u>AWMD (if req)</u> 1A20 (CoP) | <u>1st Aid</u> 1A20 (CoP) | <u>CPR</u> 1A20 (CoP) | <u>MET</u> | <u>NOT MET</u> |
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Page _____ of _____

| <u>Agency Personnel and Title</u> | <u>DOH</u> | <u>EAR</u> IA26 A26.1 (CoP) | <u>CCHS</u> IA25 A25.1 (CoP) | <u>IST</u> IA37 (CoP) | <u>AWMD (if req)</u> IA20 (CoP) | <u>1st Aid</u> IA20 (CoP) | <u>CPR</u> IA20 (CoP) | <u>MET</u> | <u>NOT MET</u> |
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