Accr. #: ________
Date: ________
Course: ________
CL4

LEAD TRAINEE SIGN-IN SHEET

TRAINING PROVIDER INFORMATION: Training Manager must complete. Please print clearly.

Training Provider ______________________ Accreditation # ________
Street ______________________
City ______________________
State ________ Zip Code ___________
Telephone _____ - _____ - _________

Course Location: ______________________
Instructor Names **(Printed):** Instructor Names **(Signed):**

______________________ ______________________
______________________ ______________________

Telephone number(s) for instructors: ______________________
Type of Course:

☐ W	☐ W REF	☐ S	☐ S REF	☐ I
☐ I REF	☐ RA	☐ RA REF	☐ PD	☐ PD REF

TRAINEE SIGN-IN: Each trainee must **print** and **sign** name, in AM and PM columns (as applicable), and then insert date of training.

	AM SESSION	PM SESSION	DATE
1			____/____/20____
2			____/____/20____
3			____/____/20____
4			____/____/20____
5			____/____/20____
6			____/____/20____
7			____/____/20____
8			____/____/20____
9			____/____/20____
10			____/____/20____
11			____/____/20____
12			____/____/20____
13			____/____/20____
14			____/____/20____
15			____/____/20____