

Community Mental Health for Central Michigan
**Individual Plan of Service/Addendum
Training Record**

Consumer Name: _____ DOB: _____ Case #: _____

Provider Agency: _____

Effective Date of IPOS/Addendum: _____

Trainer's Name: _____
Print Name *Signature* *Credentials/Title*

Date of IPOS/Addendum Training: _____

The following staff have been trained on the Individual Plan of Service/Addendum.

Name of Staff Attending <i>(please print)</i>	Name of Staff Attending <i>(please print)</i>