CHW and CHW/CRS Training Documentation Form

First Name:	Last Name:
Address:_____	
City: _____ State: _____ Zip Code: _____ County: _____	
Primary Phone:_____ Email Address:_____	
Are you currently employed? no	
If yes, where: _____	
Position Title: _____	
Are you currently employed within a mental health or addiction related agency? no	
Are you currently employed as a Community Health Worker? no	

Name of Event / Training Attended:
_____

Date of Event / Training Attended:
_____

Number of Contact Hours: _____

_____
(Instructor/Administrator Signature) (Instructor/Administrator Printed Name)

_____
Title of Instructor/Administrator Organization

Please email or fax the completed training documentation form to Kiara Bembry at kbembry@aspin.org or (317) 735-0019.

FORM MUST BE COMPLETED IN ITS ENTIRETY, OTHERWISE YOU WILL NOT RECEIVE YOUR CEU CREDIT