

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____