Alabama Long Term Care Partnership
Training Report for Medicaid Certification

As of June 30, _____
(Year)

Name	**Alabama Producer Number**	**Initial 8-Hour Training Date of Completion**	**Ongoing 4-Hour Training Date of Completion** *(Please enter all ongoing training dates, if applicable)*
Example: John Doe	*123456*	*04/01/2009*	*04/01/2011*

I certify that, to the best of my knowledge and belief, this information is true and accurate:

_____ _____
(AUTHORIZED COMPANY OFFICIAL) ***(PRINT NAME)***

Company Name _____ **NAIC #** _____

E-mail _____