Provider Training Sign-In Sheet

Trainer Name:_____

DATE: _____

TYPE OF TRAINING:

	New Provider Onboarding		PM160 Online Submission		Tool Kit:
	S.B.I.R.T.		Newborn Referral Process		Other:

PLEASE FILL OUT PROVIDER /CLINIC INFORMATION BELOW **- OR-** **STAMP CLINIC INFO HERE**

PROVIDER/CLINIC NAME: _____

PROVIDER NPI: _____

PROVIDER ADDRESS: _____

CITY: _____ **ZIP:**_____

PROVIDER TEL: _____ **FAX:** _____

ATTENDEES

	FULL NAME	POSITION	EMAIL ADDRESS (ONLY IF USED FOR WORK PURPOSES)	PHONE NUMBER	SIGNATURE
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

-ATTENDEES CONTINUED-

	FULL NAME	POSITION	EMAIL ADDRESS (ONLY IF USED FOR WORK PURPOSES)	PHONE NUMBER	SIGNATURE
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					