

Caregiver's Name: \_\_\_\_\_ Position: \_\_\_\_\_

<b>Required Documentation</b>	<b>Date Completed</b>	<b>Mandatory Renewal Date</b>
Level 2 Background Screening (expires every five years)		
Local Background Check		
Caregiver Professional Liability Insurance		
Vehicle Registration		
Vehicle Insurance		
Zero Tolerance (expires every three years)		
HIPAA (expires yearly)		
HIV/AIDS Training		
Infection Control Training		
CPR/First Aid Training (expires every two years)		
Choice and Rights of Individual (Bill of Rights)		
Complete Core Competencies Training		
Med Administration		
*CNA License		
*HHA Cert.		
*LPN License		
Other: _____		



**TRAINING FOLDER CHECK LIST**

Other: _____		
Other: _____		
Other: _____		

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

#	Staff Name	Signature	Check Date
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

**\*\*\*OFFICE USE ONLY\*\*\***

**End of year Check**

Official Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_