**IPOS Training Verification Form**

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| Client Name: | CMHSP: |
| CMHSP ID#: | WSA ID#: | [ ]  Annual IPOS [ ]  AmendmentDate of Document:  |

The staff person(s) identified below were trained on the Individual Plan of Service/Crisis Prevention or Amended Plan of Service, for the service recipient identified above. The staff was provided an opportunity to review the IPOS/Amendment document containing the plan that will be implemented, and to ask questions/receive clarification as needed. If any questions/concerns develop related to the IPOS, Crisis Prevention and/or Amended Plan, they are to be brought to the attention of the Supports Coordinator, Care Manager, Wrap Around Facilitator, and/or ABA Supervisor.

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| Training Date:  | Printed Name of Trainee  | Trainee Signature | Trainer | Trainer Credentials/Title | Trainer Signature  |
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ADDITIONAL STAFF TRAINING: Use this section for new hires and staff not available at the initial training and who were trained by a staff/parent/guardian who was previously trained in the IPOS.

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| Training Date:  | Printed Name of Trainee  | Trainee Signature | Trainer | Trainer Credentials/Title | Trainer Signature  |
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