ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH

COMMUNICABLE DISEASE TRAINING ATTESTATION

Name (please print): ____

Agency Affiliation/Job Title: ____

My signature below indicates that (check all):

- ☐ I have reviewed the Communicable Disease self-study training on _________/_____/___________.
- ☐ I have passed (scored 80% or higher) the Communicable Disease test on _________/_____/___________.
- ☐ I have achieved functional competency in the training subject matter.
- ☐ I understand that if I have any questions regarding the training subject matter, I may contact the St. Clair County Community Mental Health Training Department for clarification.

Signature: ________________________________ Date: ____________________

Upon completion of this training, please forward this training attestation to your organization's human resources/training representative.

3111 Electric Avenue
Port Huron, MI 48060
Phone: 810-985-8900