

TRANSITION AND DISCHARGE PLANNING TRAINING ATTESTATION

Name (please print): _____

Agency Affiliation/Job Title: _____

My signature below indicates that (check all):

- I have reviewed the Transition & Discharge Planning self-study training on _____/_____/_____.
- I have passed (scored 80% or higher) the Transition & Discharge Planning 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.



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