# Prevention Training Log

**Funding/Priority** (check the appropriate box)

* Tobacco
* Substance Misuse and Problem Gambling Prevention
* Mental Health Promotion

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| --- | --- | --- | --- | --- |
| Training Title | Staff Name & Email | Date | Completed  Yes/No | Number of Hours Trained |
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Did you obtain a Tobacco Treatment Specialist Certification (CTTS) or Prevention Specialist Certification (CPS) during this reporting period?

* Yes
* No

If no, provide a brief update on progress towards obtaining certification:

By signing below, I verify that I have completed the training listed above.

Staff Signature/Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor Signature/Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_