SASKATCHEWAN ASSOCIATION FOR SAFE WORKPLACES IN HEALTH

Record of PART Workshop Participation

Please check the applicable session: [ ] Basic [ ] Intermediate [ ] Advanced

Check one: [ ] initial training [ ] re-evaluation

Date of session: _____ Location: _____

Trainer(s)/
Instructor(s): _____ _____

Participant Information: (please print legibly)

Name: _____ Title: _____

Agency/facility: _____ Health Region: _____

Agency/facility address: _____

City/town: Province/Postal Code:

Email: Professional designation: RN, RPN, LPN, CCA, HHA, _____

For PART instructor or trainer use only:

[ ] Basic [ ] complete
[ ] incomplete comments: _____

_____

_____

[ ] Intermediate [ ] complete
[ ] incomplete comments: _____

_____

_____

[ ] Advanced [ ] complete
[ ] incomplete comments: _____

_____

_____

Date: _____ Signature: _____

This information should be retained in the employee file. The PART instructor or trainer may require access to this information in order to monitor sessions completed.

This form may be reproduced as required.