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Record of Re-evaluation

Date of session: _____ Location: _____

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.