SUMMIT HEAD START 0-5

EDUCATION · HEALTH · SELF SUFFICIENCY · COMMUNITY

Staff Training Tracking Form

Staff Person: ______________________________**Classroom:**______________________**Date:**_______________________

Training or Class Name: ____**Instructor:**___________________________

Training Begin Date: ____/____/______ End **Date:** ____/____/______ **Training Hours Completed:** __________

Did Head Start pay for your time at this training? ☐ Yes ☐ No
Did Head Start pay for this training? ☐ Yes ☐ No **If no, how much was the cost of this training:**_______________

Location of training/class:___________________________________ **Training is the Result of an Appraisal:** ☐ Yes ☐ No

Training Comments:

Training or Class Name: ____**Instructor:**___________________________

Training Begin Date: ____/____/______ End **Date:** ____/____/______ **Training Hours Completed:** __________

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