

**Name of Person Being Trained**

TRAINERS FILL IN TRAINEES' NAME. DO NOT HAND OUT  
WITHOUT COMPLETING THIS BOX

Ohio Department of Job and Family Services  
**PROFESSIONAL DEVELOPMENT  
DOCUMENTATION FOR CHILD CARE**

Date(s) of Training

Hours of Training

Title of Training Session

Is this training an Ohio Approved training?  
(check one) ☐ Yes ☐ No

Description of Training

**Trainer Qualifications (check one):**

At least two years' experience in subject area and meets one of the following:

☐ Completed ninety quarter credit hours or sixty semester credit hours from an accredited college, university, or technical college.  
The coursework shall include at least thirty-six quarter credit hours or twenty-four semester credit hours in courses in child development or courses related to the subject of the training.

☐ Has a currently valid CDA.

☐ Preprimary credential from the Association Montessori Internationale or the American Montessori Society.

☐ Licensed physician or registered nurse.

☐ Currently serves, and has served at least two years, in a professional capacity that directly relates to the subject of the training as it pertains to his or her professional role and shall only train within the jurisdiction of his or her job.

**I certify that the information on this form is true and accurate.**

Signature of Trainer

Trainer's Email Address

Date

Name and Address of Trainer (please print)

Telephone Number

**CHILD CARE LICENSING USE ONLY**

Date Reviewed: \_\_\_\_\_

CCLS Initials: \_\_\_\_\_

Was this electronic media training? ☐ Yes ☐ No

Provider/Administrator's Signature - verifies trainee's attendance at electronic media training

Date