carelon

Verification Form for Continuing Education Hours

Applicant's Full Name: _____

Name of Continuing Education Provider: _____

Continuing Education Provider Phone #: _____

Continuing Education Provider Site Address: _____

_____ hours of continuing education completed in the year _____

_____ hours of continuing education completed in the year _____

Continuing Education was provided in the area(s) of:

☐ Communication Skills
☐ Interpersonal and Relationship Building Skills
☐ Service Coordination and Navigation Skills
☐ Capacity Building Skills
☐ Advocacy Skills
☐ Education and Facilitation Skills
☐ Updates on applicable laws (e.g., changes in Medi-Cal eligibility) and evidence based best practices
☐ HCAI-Approve Specialty Training Program
☐ Individual and Community Assessment Skills
☐ Outreach Skills
☐ Professional Skills and Conduct
☐ Evaluation and Research Skills
☐ Knowledge Base in Public Health and Social Drivers of Health

Supervisor Printed Name: _____

Supervisor Signature: _____

Date: _____

All CHWs must complete a minimum of 6 hours of additional training annually. The supervising provider shall maintain evidence of the CHWs completing continuing education requirements in case of audit.