New Jersey Department of Human Services
Division of Developmental Disabilities

INTERIM PRE-SERVICE TRAINING PROGRAM MONTHLY REPORT

Please include data for only one training location for one month on each report and submit with payment voucher and attendance sheets

Agency:	Month Reporting:
Agency Address:	City & Zip Code:
Contact Person:	Area Code/Phone Number:
Trainer(s):	Training Location County:

Training Conducted:	Overview of Developmental Disabilities	Preventing Abuse & Neglect	Medication	Adult CPR & First Aid	Total Numbers
Number of Sessions Presented					
Number of Cancellations (Include Dates, Reasons)					
Number Registered					
Number of Internal Staff Attended & Completed					
Number of External Staff Attended & Completed					
Number Not Completed (Fail, Incomplete)					
Number of No Shows by External Staff					

Signature: _____ Title: _____

Printed Name: _____ Date: _____