

STATE OF ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES TRAINING COMPLETION FORM



DATE:		
TO:	DHSS Training Coordinator Department of Health & Social Services Division of Administrative Services Director's Office	
RE:	Completion of Training	
This mem	no certifies that the employee has completed the following course:	
EMPLOY	YEE:	
SSN:		
DIVISION:		
LOCATI	ION:	
COURSE	E TITLE:	
INSTITU	JTION OFFERING THE COURSE:	
DATES (OF COURSE:	
Signature	e of Supervisor: Date:	