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 memo certifies that the employee has completed the following course:

EMPLOYEE: _____

SSN: 111-11-1111

DIVISION: Public Assistance

LOCATION: Location

COURSE TITLE: _____

INSTITUTION OFFERING THE COURSE: _____

DATES OF COURSE: _____

Signature of Supervisor: _____ **Date:**_____

Print Form

Clear Form