NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

Division of Behavioral Health
Office of Consumer Affairs
P.O. Box 95026
Lincoln, Nebraska 68509-5026

VERIFICATION FORM FOR COMPLETED PEER SUPPORT TRAINING IN 2018

THIS FORM IS TO BE COMPLETED BY THE TRAINER WHO PROVIDED THE PEER SUPPORT TRAINING IN 2018.

THIS IS TO VERIFY THAT:

The records of:_____
(Name of Organization)

Employer Address:_____
(Include City, State and Zip Code)

Indicate that:_____ provided
(Trainer First and Last Name) (Title)

peer support training to _____ .
(Trainee First and Last Name)

The above stated trainee successfully completed _____hours of training on _____
(Hours) (Date)

that I provided and demonstrates an understanding of the core functions of a peer worker.

My signature below indicates that the information contained herein is true and complete.

Applicant Printed First and Last Name

Applicant Signature **Date Signed**

Trainers Printed First and Last Name and Job Title

Trainers Signature **Date Signed**

Trainers Email Address **Trainers Phone Number**