



EVERY WOMAN MATTERS

Provider Training Outcomes (to be completed by Case Manager)

Copy this page and send to Quality Assurance Coordinator Quarterly

Clinic Name _____ Region _____

Date of Training _____ Onsite _____ Phone _____

Implementation of	Clinic Staff verbalizes understanding at time of training	Clinic Staff Needs further training/information*	Not applicable	Comments
1. Revised 2009 Screening card				
2. Revised 2009 Presumptive Enrollment form				
3. December 2009 Cervical Policies & new Cervical Enrollment/ follow-up & Treatment form				
4. December 2009 Breast Policies & new Breast Enrollment/ follow-up & treatment form				
5. December 2009 CVD/Diabetes Policies				
6. Report of Women Deemed Lost to follow up form				
7. Client Informed Refusal Form				
8. Treatment Funds Request Form				
	Clinic Staff Demonstrates knowledge	Clinic Staff Needs further training/information*	Not applicable	Comments
9. Straight Talk about Breast Cancer/ book				
10. Guia Para la Mujer Sobre El Diagnostico Y El Tratamiento Del Cancer Del Seno (A Woman's Guide to Breast Cancer Diagnosis & Treatment)				
10. Online Provider Manual				
11. Nebraska Colon Cancer Program				
12. Current Professional Education Information				
13. EWM Promotional Materials				
14. Clipboards order form				

Provider Training Sign In Sheet

Clinic Name _____

Date of Training _____

#	Name	Position/Title
1.		
2.		
3.		
4.		
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18.		
19.		

Comments _____

* See Page 3 for Follow up training plans--to be completed with all training sessions

Provider Training Follow Up

To be completed with all training sessions

Section A To be completed at initial training session

Provider/clinic name _____ Contact person _____

Date of initial training session _____

_____ onsite _____ phone _____ email

Scheduled date of follow up training session _____

Issues to be addressed at follow up session

_____ Forms (list) _____

_____ Other (list) _____

Section B To be completed at Follow up training session

Date of session _____

_____ onsite _____ phone _____ email

Issues addressed (list)	Response by staff
_____	_____
_____	_____
_____	_____
_____	_____

Comments _____

Further follow up plan

Scheduled date for follow up _____

_____ onsite _____ phone _____ email

Section C To be completed if no follow up is scheduled

Future follow up to be initiated by

_____ clinic staff (name) _____

_____ case manager tentative date _____

Provider Training Sign In Sheet For Follow up Session

Clinic Name _____

Date of Training _____

#	Name	Position/Title
20.		
21.		
22.		
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