ATTACHMENT H

LCTS Training Verification Form

County Name _____

LCTS Coordinator's Name _____

The following people have been trained and are newly certified: **(Please print legibly or type)**

Position:

C = LCTS Coordinator
T = Trainer
F = LCTS Fiscal Reporting & Payment Agent
FC = Fiscal Site Contact

Partner:

Write the ISD # to identify the School District
P = Public Health
C = Corrections
(In some cases, partner identification will not be necessary)

	Name	Email	Position	Partner	Training Date
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

LCTS Coordinator's Signature: _____
(Required for positions "C" and "T")

LCTS Fiscal Reporting & Payment Agent's Signature: _____
(Required for positions "F" and "FC")

Return this form to:

LCTS Project Manager
DHS Financial Operations Division
P.O. Box 64940
St. Paul, MN 55164-0940
Fax: 651-431-7480