CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR COMMUNITY BASED SERVICES  
FOSTER/ADOPTIVE PARENT TRAINING DOCUMENTATION

Submitted by: ____________________________ Phone/Email: ________________________________

| TITLE OF TRAINING: | | |
| | | |

<table>
<thead>
<tr>
<th>TYPE OF TRAINING</th>
<th>TYPE OF DELIVERY</th>
<th>SITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 01 Central Office</td>
<td>☐ 01 Group</td>
<td>☐ 01 FP County</td>
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<tr>
<td>☐ 02 Region Office</td>
<td>☐ 02 One on One</td>
<td>☐ 02 FP Region</td>
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<tr>
<td>☐ 03 Recruitment &amp; Certification</td>
<td>☐ 03 Individual</td>
<td></td>
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<tr>
<td>☐ 04 Other(employment, community, etc.)</td>
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</tbody>
</table>

CHECK ONLY ONE BOX IN EACH COLUMN

Check the box that most accurately describes the training category. CHECK ONLY ONE BOX!

01 PROTECTING AND NURTURING
   ☐ 01 Maintaining a safe, healthy home environment for foster children
   ☐ 02 Discipline and behavior management
   ☐ 03 Caring for children who have been neglected; emotionally, physically or sexually abused

02 MEETING THE NEEDS OF FOSTER CHILDREN
   ☐ 01 Developmental
   ☐ 02 Emotional
   ☐ 03 Health and Medical
   ☐ 04 Educational

03 PROMOTING PERMANENCY OUTCOMES
   ☐ 01 Reunification
   ☐ 02 Adoption
   ☐ 03 Independent Living
   ☐ 04 Permanent Substitute Care
   ☐ 05 Supporting Primary Relationships

04 WORKING AS A PROFESSIONAL TEAM MEMBER
   ☐ 01 Partnership with the Department
   ☐ 02 Advocacy
   ☐ 03 Court
   ☐ 04 SOPs and Procedures
   ☐ 05 General

05 PRESERVICE
   ☐ 01 Preparation

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DOB(MM/DD): ____________ HOURS Earned: ____________
FIRST NAME: ________________
MIDDLE: ________________  ☐ 01 The Lakes  ☐ 04 Jefferson  ☐ 07 Northeastern
LAST: ________________  ☐ 02 Two Rivers  ☐ 05 Northern Bluegrass  ☐ 08 Eastern Mountain

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Form must be completed and submitted online to FAP-TRIS within five business days of the training ending.  
Phone: (859)622-8820  http://tris.eku.edu