ALLEVIANT
HEALTH CENTERS™
Heal Pain. Restore Hope. Regain Purpose.

TRAINING Summary Form *(to be completed within 7 business days of the training completion)*

Name of employee: _____ Date of summary: _____

Name of training: _____

Training Date(s): _____ # of hours attended _____
(Attach copy of certificate of CE)

Evaluation of the Training

1. Would you recommend this training to other? Why/Why not?

   _____

   _____

   _____

2. What are 3 take aways that you will be able to use in your work at Alleviant?

   _____

   _____

   _____

3. Other comments:

   _____

   _____

   _____