Autism Mentor Standard 2 Verification Form

Date submitted: ____

County: ____________________________ County Phone #: _________________________________

County Address: ____

Personnel Director: ______________________________ Email: ___________________________________

Special Ed Director: ______________________________ Email: ___________________________________

Name of Mentor: ________________________________ Phone #: ________________________________

Address: ____

Staff Development Documentation---Total of 30 Hours Required

Prevention and De-escalation Techniques with Alternative to Restraint (Required)

Prevention and De-escalation Training

Date of Training: ___________________________________ Number of Hours: _______________________

Agency Providing Training: ____

Title of Training: ____

Date of Training: ___________________________________ Number of Hours: ______________________

Agency Providing Training: ____

Title of Training: ____

Date of Training: ___________________________________ Number of Hours: ______________________

Agency Providing Training: ____

Staff Development Related to Providing Instructional Support to Student with Autism

Title of Training: ____

Date of Training: _________________________________ Number of Hours: _____________________

Agency Providing Training: ____

Title of Training: ____

Date of Training: _________________________________ Number of Hours: _____________________

Agency Providing Training: ____

Title of Training: ____

Date of Training: _________________________________ Number of Hours: _____________________

Agency Providing Training: ____

If additional training space is needed please attach additional forms.

Signed training agendas by trainers or designees must accompany this form.