

**Provider Orientation Training  
Video Sign-off Sheet**

Training Video:

1. Review Processes Date Viewed:

1. Quality Improvement Date Viewed:
2. Resource Administration Date Viewed:

Provider/Agency Name:

Executive Director Name:

(Principal of Entity)

\*Signature or typewritten name is acceptable.

You will have the opportunity to ask questions relating to the content of the video at the Provider Orientation Training.

\*Electronic signature: By signing this document, I guarantee this is my electronic signature. I attest that the information provided is true. If any statements are willfully false, I realize I am subject to perjury/false statements.

**Email this form to DDS.QPAPenrollment@ct.gov**