TUSCOLA BEHAVIORAL HEALTH SYSTEMS
A Michigan Community Mental Health Authority serving Tuscola County

Plan of Service – In-Service/Training Form (B)

I acknowledge that I have been in-serviced/trained and understand the contents of the attached Document and agree to implement as written.

Consumer:	Consumer #:	PCP Date:
Document: ☐Addendum ☐IPOS	☐Home/CLS ☐PIC/CLS ☐ABA Provider ☐Other:_____	
Document Date:	☐ SC/TCM ☐ACT ☐ HBS ☐ RN ☐ OT ☐ PT ☐ BTP ☐ RD ☐ SLP	
Trainer(s): (Including Title – Identified as Trainee(s) on Form A)		

Printed Name	Signature	Date of Training
Printed Name	Signature	Date of Training
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