

COURSE COMPLETION REPORT



DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Healthy Homes and Lead Poisoning Prevention

YOU MUST SUBMIT A SEPARATE FORM FOR EACH COURSE COMPLETION REPORT

DATE OF NOTIFICATION:

(MM/DD/YY)

CERTIFIED TRAINING PROVIDER

NAME:

ADDRESS:

TELEPHONE NUMBER:

CERTIFICATION NUMBER:

TRAINING MANAGER'S NAME:

TRAINING MANAGER'S SIGNATURE:

PRINCIPAL INSTRUCTOR'S NAME:

COURSE NAME/DISCIPLINE:

COURSE TYPE (INITIAL/REFRESHER):

COURSE LANGUAGE:

COURSE DATES:

COURSE TIMES:

TRAINING LOCATION

ADDRESS:

TELEPHONE NUMBER:

COURSE COMPLETION REPORT

	STUDENT NAME	STUDENT ADDRESS	DATE OF BIRTH	CERTIFICATE NUMBER	TEST SCORE
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					

COURSE COMPLETION REPORT

	STUDENT NAME	STUDENT ADDRESS	DATE OF BIRTH	CERTIFICATE NUMBER	TEST SCORE
20					
21					
22					
23					
24					
25					