L.A. Care HEALTH PLAN

For All of L.A.

L.A. Care Health Plan Sign-In Sheet

Name of PPG/PCP/Specialist/Hospital/Other: _____

Training Name: _____

Facilitator Name: _____

Facilitator Contact Number: _____

Training Location: _____

Date of Training_____Time of Training:_____

Print Name (First and Last)	Signature	Job Title	Email Address

By signing your name above, you attest that you have completed the training or attended the event indicated on this sign-in sheet.

Print Name (First and Last)	Signature	Job Title	Email Address

By signing your name above, you attest that you have completed the training or attended the event indicated on this sign-in sheet.

*LA CARE FORMS AND THE LANGUAGE CONTAINED HEREIN ARE NOT TO BE ALTERED