

Certificate of Training

Name: _____

Who is a: CDS Employer
 CDS Employer's Designated Representative

Client name: _____

**I attest that I watched the Consumer Direct Care
Network's EVV Policy Video in its entirety on**

Training Date*: _____

Signature: _____
(Employer/DR Signature)

Is Awarded this Certificate by



*This training is required initially and then annually.
This certificate will expire one year from date of training completion.



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