{COVERED ENTITY NAME}

PRIVACY TRAINING CERTIFICATE

Purpose: This form is used to certify completion of privacy training by a workforce member. Retain the form for at least six years form the date noted below.

**Section A—Workforce member trained.**

Name:

Department:

Job Title:

Work Address:

Telephone: E-mail:

Employee ID:

Date privacy training completed: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Privacy training hours:

Reason for privacy training:

# SIGNATURE OF PRIVACY INSTRUCTOR.

I attest that the above information is correct.

Signature: Date:

Print name: Title:

**SECTION B—Workforce member’s training acknowledgement.**

I attest that I completed training on our health plan's privacy policies and procedures as set out above.

Signature: Date:

Print name: Title:

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