Kindred Healthcare

KINDRED HEALTH CARE, INC.
EDUCATION/TRAINING ATTENDANCE ROSTER

Program Title HIPAA – PRIVACY IN THE WORKPLACE **Date** _____

Facility Name _____ **Facility #** _____ **Course Material Attached?** **Yes** _____ **No** _____

Trainer /Facilitator Name _____ **Signature** _____

Signature of Trainer or Facilitator certifies that the following persons attended the training.

NAME	TITLE	SIGNATURE	LAST 4 DIGITS SSN
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My signature indicates I attended the training program identified on this form.