

**MID-SOUTH SUBSTANCE ABUSE COMMISSION**  
**VERIFICATION OF COMMUNICABLE DISEASES BASIC KNOWLEDGE**

**Program Name:** \_\_\_\_\_

The purpose of this document is to provide verification that the personnel listed below have, at a minimum, a basic knowledge of Communicable Disease and its relationship to substance abuse. This documentation is accompanied by the knowledge that this verification needs to be applied to **all** treatment providers, **including program directors and staff who provide services** to the public. All new hires are to have the appropriate level of Communicable Disease training within the first three (3) months of hire and updated every two (2) years thereafter.

\_\_\_\_\_  
Signature of Authorization

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Signers Position

**Listing of Personnel**

<b>Name:</b>	<b>Position:</b>	<b>Date of Training:</b>	<b>Update Completed:</b>