



MDS-HC/Care Planning Training Registration Form

Trainee Name:

Trainee Title:

Trainee E-mail:

Supervisor Name:

Agency Name:

Supervisor E-mail:

Address:

Phone:

Type of training class:

MDS-HC Assessment

Care Planning

Recertification

Regional location:

Baton Rouge

Alexandria

Month you wish to attend:

Please indicated if you have previously attended any of the following training classes:

MDS-HC

Care Planning

Recertification

If you selected a training class above, provide the date of attendance.

Please select "submit" at the top of the registration form to submit to OAASMDS-HC&CPTRAINING@la.gov or send file as an e-mail attachment . Once we have received your registration form, you will receive a confirmation e-mail along with the formal training announcement & calendar.

In the event you are unable to attend the training class, please e-mail OAASMDS-HC&TRAINING@LA.GOV.

**If any special accommodations are needed, please let us know in advance.