

<input type="checkbox"/>	Med Sled	
<input type="checkbox"/>	Back Belt	
<input type="checkbox"/>	Wedge (Specify):	_____
<input type="checkbox"/>	Hand Splints	
<input type="checkbox"/>	Prader Willi	
<input type="checkbox"/>	AFOs	
<input type="checkbox"/>	Fleets Enema	
<input type="checkbox"/>	Other (Specify):	_____
<input type="checkbox"/>	Other (Specify):	_____
<input type="checkbox"/>	Other (Specify):	_____

Trainer Initials	Employee Initials	Date Completed

By signing below, I acknowledge that I was present and understand all of the information presented to me.

X _____
Employee's signature and title

X _____
Trainer's signature and title

X _____
Trainer's signature and title

Please submit this form to HR for the Employee's Medicaid File