BrightPath

Staff Orientation Record: Person-Specific

Employee name: _____Ashley Myhre_____

Program name: BrightPath LLC. Home & Community Based Services

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. *Complete this form for all persons served to whom the staff person will be providing direct contact services.

Staff will review Support Plan, Support Plan Addendum, Self Management Assessment, and Individual Abuse Prevention Plan at orientation, and ongoing as plans are updated. Staff will review to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person. Other topics as determined necessary according to the person's Service and Support Plan or identified by the company will be outlined as needed.

Orientation to Individual Service Recipient Needs				
Name of Individual Served	**Support Plan, Support Plan Addendum, Self Management Assessment, and IAPP Reviewed?**	**CPR, if required by the Support Plan or Support Plan Addendum?**	**Hours of Training**	**Name of Instructor + Type of Competency**
Diane Oldeen	**Support Plan, Support Plan Addendum, Self Management Assessment, and IAPP**	N/A	**.5**	Instructor Name: Type of Competency: ☐ Quiz ☐ Discussion w/ Designated Coordinator ☑ Self-Review ☐ Observation

Name of Individual Served	Support Plan, Support Plan Addendum, Self Management Assessment, and IAPP Reviewed?	CPR, if required by the Support Plan or Support Plan Addendum?	Hours of Training	Name of Instructor + Type of Competency
		N/A		Instructor Name: Type of Competency: ☐ Quiz ☐ Discussion w/ Designated Coordinator ☐ Self-Review ☐ Observation
		N/A		Instructor Name: Type of Competency: ☐ Quiz ☐ Discussion w/ Designated Coordinator ☐ Self-Review ☐ Observation
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		N/A		Instructor Name: Type of Competency: ☐ Quiz ☐ Discussion w/ Designated Coordinator ☐ Self-Review ☐ Observation

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		N/A		Instructor Name: Type of Competency: ☐ Quiz ☐ Discussion w/ Designated Coordinator ☐ Self-Review ☐ Observation
		N/A		Instructor Name: Type of Competency: ☐ Quiz ☐ Discussion w/ Designated Coordinator ☐ Self-Review ☐ Observation
		N/A		Instructor Name: Type of Competency: ☐ Quiz ☐ Discussion w/ Designated Coordinator ☐ Self-Review ☐ Observation
		Total Training Hours:	**.5**	

Signed by:
Diana Nelson
C63B13AC68AD4D6...
Trainer Signature

1/14/2025
Date

DocuSigned by:
Ashley Mylire
07F93C8685B2470...
Employee Signature

1/16/2025
Date

*I understand the information I received and my responsibilities for their implementation in the care of persons served by this program.