



Staff Orientation Record: Person-Specific

Employee name: Kristi Lemair

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
Kimberly Rice	yes	N/A	2	Instructor Name: Amber Cairl Type of Competency: <input checked="" type="checkbox"/> Quiz <input checked="" type="checkbox"/> Discussion w/ Designated Coordinator <input type="checkbox"/> 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
Adriel Ramirez	yes	N/A	2	Instructor Name: Amber Cain Type of Competency: <input checked="" type="checkbox"/> Quiz <input checked="" type="checkbox"/> Discussion w/ Designated Coordinator <input type="checkbox"/> Observation
		N/A		Instructor Name: Type of Competency: <input type="checkbox"/> Quiz <input type="checkbox"/> Discussion w/ Designated Coordinator <input type="checkbox"/> Observation
		N/A		Instructor Name: Type of Competency: <input type="checkbox"/> Quiz <input type="checkbox"/> Discussion w/ Designated Coordinator <input type="checkbox"/> Observation
		N/A		Instructor Name: Type of Competency: <input type="checkbox"/> Quiz <input type="checkbox"/> Discussion w/ Designated Coordinator <input type="checkbox"/> Observation
		N/A		Instructor Name: Type of Competency: <input type="checkbox"/> Quiz <input type="checkbox"/> Discussion w/ Designated Coordinator <input type="checkbox"/> 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: <input type="checkbox"/> Quiz <input type="checkbox"/> Discussion w/ Designated Coordinator <input type="checkbox"/> Observation
		N/A		Instructor Name: Type of Competency: <input type="checkbox"/> Quiz <input type="checkbox"/> Discussion w/ Designated Coordinator <input type="checkbox"/> Observation
Total Training Hours:				

Trainer Signature

Keith Lewis

Date

02/06/25

Employee Signature

[Signature]

Date

02/06/25

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