Community Care Resources, Inc.

Partnership in Planning

Verification of Professional Consultation

Consult with Therapist, Psychiatrist, or Psychologist

Foster Parent Name:_____ **Foster Child Initials:**_____
(Each parent is required to fill out their own individual form.)

Professional Name/Title:_____

Date of Consultation:_____

New Skill Taught by Professional:_____
or
Materials Reviewed with Professional:_____

Summary Questions: (Answers **required**.)

1. **What was this training about? What treatment issues are addressed in this training?**

2. **Name 3 things in the material presented that you liked:**

3. **Based on what you learned, what will you implement in your home/parenting today:**

By signing or typing my name into this form, I acknowledge that I have completed the training as entered above

Foster Parent Signature:_____ **Date**: _____

Professional Signature*: _____ **Date**: _____
***Physical Signature required**

Total hours: _____

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www.CommunityCareResources.com