E. Shoshone Dept. of Family Services
Foster Care Program
Continuum Training Hours
Record Document

Names of foster parents: ____

Phone number: ______________________________

ID #________________________ Re-licensing Date: _______________________

Training Date	name of training	presenter's name	location	total of training hours	who attended:	presenter's Signature

The ____________________________ family has completed the (18) hours of continuum training hours which is a requirement to maintain licensure as a foster family with the E. Shoshone Dept. of Family Service.

____ ____

Foster parent signature & Date ***Foster parent signature & Date***

Please mail this document once hours are completed to:

ESDFS-Foster Care Coordinator P.O Box #945 Ft. Washakie, WY 82514