County of Santa Cruz

2020-2021 Annual CMAA Training

Unit: _____

Date of Training: _____

	Last Name	First Name	Training Location	Phone	Claiming Unit	Signature (Blue Ink)
1						
2						
3						
4						

TRAINER'S CERTIFICATION:

I CERTIFY THAT THE PARTICIPANTS ABOVE HAVE ATTENDED THE CMAA TIME SURVEY TRAINING IN COMPLIANCE TO THE STATE/FEDERAL RULES AND REGULATIONS.

Signature of Trainer (in blue ink): _____

Name of Trainer (printed): Nikki Yates

Classification of Trainer: LGA Coordinator

Trainer's date of Training: _____

SUBMIT/MAIL THE ORIGINAL DOCUMENT TO:

MEDI-CAL ADMINISTRATIVE ACTIVITIES

HEALTH SERVICES AGENCY

1800 Green Hills Road, Suite 240

Scotts Valley, CA 95066

NOTE: PLEASE KEEP A COPY IN YOUR AUDIT FILE.