TRAINING ATTESTATION

I acknowledge I have received and reviewed the Training Information that includes:

- Continuous Quality Improvement
- Corporate Compliance and HIPAA Training
- Diversity
- Emergency Preparedness
- Environment of Care
- Fire Safety
- Identification and Treatment of Family Violence
- Infection Control
- Patient Rights
- Practitioner Impairment
- Right to Know
- Pain Management

Print Name:______________________________

Signature: ______________________________

Date: ______________________________

If I required any additional information or had any questions regarding any of the specific training, I contacted the respective department as indicated.

FAX or MAIL form to:

FAX: 631-444-6031

Stony Brook University Hospital
Medical Staff Services Dept T-14
Stony Brook, NY 11794-7148