SDOH Screening and Referral Training

Date: _____

Agency / Clinic: _____

Name(s) and Position of Individuals:

Name:	Position:

I (we) attest that we have completed the below trainings from the ORPRN and OHA Transformation Center Resource Guide:

☐ **Trauma Informed Care**

☐ **Motivational Interviewing**

☐ **Empathic Inquiry**

☐ **Empathic Inquiry, Social Needs Screening Data & Clinical Workflows**

I (we) chose to complete a similar training that included the above topics.

Name(s) of Training(s):

_____

_____

Signature of Individual(s) listed above:

_____ _____

_____ _____

_____ _____

Instructions for Completion: This form may be completed by printing and ink signature or by electronic Digital Signature ID. Please send the completed form to providerrelations@yamhillcco.org