**ECS PROVIDER ATTESTATION FORM**

*Please complete for each provider and return to: Stephanie Norton*

**AGENCY NAME:**

<table>
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<tr>
<th>STAFF NAME:</th>
<th>POSITION:</th>
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**Course** | **Supervisor Signature & Date**

Provider attests to maintaining records including the following:
- Names of all covered individuals
- Evidence of licensure, certification or accreditation
- Evidence of insurance coverage
- Evidence of required staff training
- Evidence of TB test
- Evidence of DFPS Automated Background Check System (ABCS)
- If covered individuals are paid by Provider, evidence of compliance with Department of Labor (DOL) regulations regarding salaries and pay

**CPR / FIRST AID / SEIZURES**

- Infection Prevention
- HIPAA for Healthcare Professionals
- Client Rights, Abuse, and Neglect
- Childhood Illnesses
- Home Visit Safety
- Child Maltreatment
- Service Animal Accommodation
- Safe Sleep for Babies
- Typical & Atypical Child Development
- Period of Purple Crying