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|  | DOMESTIC VIOLENCE INTERVENTION TREATMENT (DVIT) PROGRAM  **Continuing Education Summary for DVIT Providers**  Washington Administrative Code 388-60B-0275 | | | | | | |
| DIRECT TREATMENT STAFF’S NAME | | | | DVIT PROGRAM’S NAME | | | |
| Two years (40 hours) continuing education summary from:  to:  DATE DATE | | | | | | | |
| **Domestic Violence Intervention Treatment Training** | | | | | | | |
| All staff having direct treatment contact with participants must complete a minimum of ten hours of continuing professional education in domestic violence intervention treatment each year after the program is certified, or each year after the staff person is added. | | | | | | | |
| COURSE / WORKSHOP / SEMINAR TITLE | | DATE: MM/YYYY | PRESENTER / SPONSOR | | | HOURS COMPLETED | RELATIONSHIP TO DVIT |
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| **Domestic Violence Victim Training** | | | | | | | |
| All staff having direct treatment contact with participants must complete a minimum of nine hours of continuing professional education in victim training each year after the program is certified, or each year after the staff person is added. | | | | | | | |
| COURSE / WORKSHOP / SEMINAR TITLE | | DATE: MM/YYYY | PRESENTER / SPONSOR | | | HOURS COMPLETED | RELATIONSHIP TO DV VICTIM SERVICES |
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| **Suicide Prevention** | | | | | | | |
| All staff having direct treatment contact with participants must complete a minimum of one hour of continuing professional education in suicide prevention training each year after the program is certified, or each year after the staff person is added. | | | | | | | |
| COURSE / WORKSHOP / SEMINAR TITLE | | DATE: MM/YYYY | PRESENTER / SPONSOR | | | HOURS COMPLETED | RELATIONSHIP TO DV |
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| **This form must be accompanied by completion certificates, course / workshop outline, and supervisor signature.**  I verify under penalty of perjury that the information provided on this form for CEUs is true and correct. I understand that any material misrepresentation or misstatement of fact may result in sanctions, including the denial or loss of program certification. | | | | | | | |
| SUPERVISOR’S SIGNATURE DATE | | | | | PRINT SUPERVISOR’S NAME | | |