COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services
Division of Child Care

Select Provider Type:
- ☐ Licensed Type I
- ☐ Licensed Type II
- ☐ Certified

STARS for KIDS NOW Interim Report
Staff Training Documentation

Date Completed: _____

Completed by *(name and title)*: _____

Facility Name: _____

License or Certificate Number: _____

Current Enrollment: _____ **Number of Staff:** _____ **STARS rating anniversary date:** _____

Training Documentation MUST be Completed for All Staff

Staff Person Name: _____ **Hire Date:** _____ **Full-time** ☐ **Part-time** ☐

Credential/Degree: Yes ☐ **No** ☐ **If yes, please list and attach copy** _____

CPR: Yes ☐ **No** ☐ **If yes, expiration date:** _____ **First Aid: Yes** ☐ **No** ☐ **If yes, expiration date:** _____

Date staff development/training plan completed: _____ **Date staff STARS Overview Completed:** _____

Date staff evaluation completed: _____ **If employed less than 12 months, date to be completed:** _____

Method used to calculate training for STARS rating: ☐ **Hire Year** ☐ **Rating Year (list year:** _____**)**

Training Date	Training Name	Training Source	Trainer Name and Credential Number	# Clock Hours