**Attachment B**

**Review of Progress: Information and Options Counseling Staff**

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Staff #1 Staff #2 Staff #3 Staff #4

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| --- | --- | --- | --- | --- |
| Staff First and Last Name: |       |       |       |       |
| 1. Date staff’s I&A  responsibilities started  |       |       |       |       |
| 1. 2. Date Options

 Counseling duties started (if applicable) |       |       |       |       |
| 1. 3. Date orientation completed

 (*Mark for first year only*) |       |       |       |       |
| 1. Annual 10 hours of training completed for each I/OC staff. \**Specify year reviewed and total number of training hours* (Ex: 2025,12 hours)
 |       |       |       |       |
| 5. Assessment of competence is  addressed by supervisor:  specify date(s) (i.e. annual review) |       |       |       |       |

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