**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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