COVID-19

MAP CERTIFICATION REINSTATEMENT ATTESTATION FORM

Date:_____

Provider Agency:_____

Name of staff: Last name, First name	Date of Birth

I ATTEST THAT THE ABOVE STAFF HAVE COMPLETED A MAP CERTIFICATION REINSTATEMENT REFRESHER TRAINING AND THEIR PREVIOUS MAP CERTIFICATION WAS IN GOOD STANDING (NOT SUSPENDED OR REVOKED) PRIOR TO EXPIRATION AND THEY WERE PREVIOUSLY MAP CERTIFIED WITHIN THE LAST 24 MONTHS.

Person/Title completing form:

_____

Date:_____