

**Miami- Dade County Public Schools (M-DCPS)  
Supplemental Educational Services (SES)  
Provider Staff Training Assurance Form**

Please print or type the following information:

Name of Provider: \_\_\_\_\_

As the authorized representative for this Provider, I certify that all the staff have been trained in the following areas:

1. M-DCPS Procedures and Guidelines for the Implementation of SES Program
2. M-DCPS Code of Ethics and Conduct
3. Child Abuse Reporting
4. Accident/Incident Reporting
5. Confidentiality of Student Information
6. M-DCPS Emergency Procedures
7. Student Emergency Contact Information
8. Student Dismissal Procedures
9. Student Sign In/Sign Out Procedures
10. Student Attendance Recording
11. Student Learning Plan (SLP) and Progress Report
12. Pre-and Post-Assessment Procedures and Reporting
13. Provider's SES Program and Curriculum
14. Usage of Supplies and Equipment
15. Instructional Materials and Supplies
16. District Requirements and Procedures for Fingerprinting/Background Screening Clearance
17. All State Mandated Training

I also acknowledge that:

- ✓ No SES will be delivered by a tutor prior to the tutor receiving background and drug screening clearance from the Title I Administration office.
- ✓ Instructional materials for program implementation were provided for all tutors.

**I certify that I am an individual authorized to act on behalf of the organization in submitting this Assurance as indicated on Appendix H, and that all the information provided herein is true and accurate to the best of my knowledge. I verify that the attached list contains the name and title of all staff members that have been trained in all area indicated above. I understand that the staff will not begin offering services until approval is received from the M-DCPS Title I Administration Office. I further certify that this organization will continue complying with all staff training requirements during the duration of the services stipulated in the contractual agreement with M-DCPS, and that newly hired staff will be trained within 30 days of employment with this organization.**

\_\_\_\_\_  
Provider Representative Name & Title (print or type)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

