

EMPLOYER INFORMATION		
Company Name	Street	
City/Town	State	Zip
Website	Telephone	

This is to verify that _____ has successfully completed _____ training modules that were evaluated for college credit by Bismarck State College.

- Years of experience in related position _____
- Length of time spent on training _____
- Training Delivery (classroom, labs, hybrid, etc.) _____
- Assessment used to measure training outcomes (exams, test-out, etc.) _____
- Dates training was completed for individual _____

Attachments to be included:

1. Outline of training showing training objectives, date completed, and training hours.
2. Assessment of training outcomes (exams, test out, etc.)
3. Copy of certification received.

TRAINING AUTHORITY		
Last Name	First Name	Title
Email Address	Telephone	
VERIFICATION TRAINING AUTHORITY		
I verify the person named above has completed the training indicated on this form.		
Signature:	Date:	

Submit by mail to:
Alternative Learning Office
Bismarck State College
PO Box 5587
Bismarck, ND 58506
10/17/2014