LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
CHILDREN'S SYSTEM OF CARE
FIRST 5 LA PARENT CHILD INTERACTION THERAPY (PCIT)
WEEKLY TRAINING SIGN-IN LOG for Providers

Agency's Name: _____ Date: _____

Provider Number: _____

Clinician's Name	Clinician's Signature	License/Waiver #	Total Hours
Total Weekly Hours	**Supervisor's Signature_____**		

Email this completed form to Daphne Quick-Abdullah at dquickabdullah@dmh.lacounty.gov

*****NOTE***THIS SIGN-IN LOG IS FOR TRAINING STIPEND HOURS ONLY AND SHOULD NOT INCLUDE HOURS BILLED TO THE DMH ELECTRONIC SYSTEM DURING TRAINING.**