



INSURANCE GROUP 25 New Chardon St • Boston, MA 02114-4721 • Phone: (617) 488-6500 • Fax: (617) 488-6502

**EMPLOYEE RETRAINING CERTIFICATION**

To be completed following a work related injury or improper working procedures observed

EMPLOYER'S NAME: \_\_\_\_\_

**I. RETRAINING COMPLETED**

Employee Name	Department
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The following topic(s) were covered in the retraining and reeducation:


**II. ACKNOWLEDGMENT**

I acknowledge that I was retrained and reeducated as per above. I understand the information provided to me in the retraining. Based on the information, I can give a proper demonstration of the techniques. I understand this document will become a part of my employment file.

Employee Signature:	Date:
Educator/Trainer Signature:	Date: