# SEMI ANNUAL ASSESSMENT OF TRAINING EFFECTIVENESS AND NEEDS

**Employee Name:** _____ **Job Title:** _____

**Assessment Date:** _____ **Department:** _____

**IF ALL TRAINING HAS BEEN EFFECTIVE AND NO ADDITIONAL TRAINING IS REQUIRED IN THE UPCOMING 6 MONTHS, CHECK HERE:** ☐

| ADDITIONAL TRAINING / RE-TRAINING REQUIRED | SCHEDULED COMPLETION DATE (MONTH/QUARTER) |
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Assessing Manager's signature: _____

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