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)

Assessing Manager's signature: _____

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