

Training Record Form

No. :

Training Subjects			
Training Objectives			
Evaluation Methods	<input type="checkbox"/> Written Examinations <input type="checkbox"/> Job Practice Evaluation	<input type="checkbox"/> Oral Q&A <input type="checkbox"/> Others :	
Time of Training		Duration	
Lecturer		Place of Training	

Sign-in Detail

Employee No.	Name	Department		Employee No.	Name	Department

Assessment Conclusion :

_____ participants attended in this training; _____ participants passed the evaluation assessment.

Recorded by/Date :