ONTARIO MINOR HOCKEY ASSOCIATION
HOCKEY TRAINER CERTIFICATION PROGRAM
TEAM TRAINER QUALITY ASSURANCE REPORT

Trainer's Name:_____Level:____Date Supervised:_____
HCR ID #:_____Expiry Date:_____
Address:_____
Telephone: Home ( )_____ Email:_____
Trainer's Home Centre:_____Team:_____Division:_____
Game/Practice Played at:_____

Areas of Emphasis to Meet Responsibilities and Code of Ethics

	SATISFACTORY	***NEEDS IMPROVEMENT***	***NOT APPLICABLE***	***COMMENTS***
Medical History Files				
First Aid Kit				
Protective Equipment				
Male/Female Players				
Warm-up/Conditioning				
Knowledge				
E.A.P.				
Player Medications				
Player Special Needs				
Risk Management				
Universal Precautions				
Hydration				
Abuse & Harassment				
Attitude				
Communication				
First Aid Certified				

Comments/Recommendations:_____

_____

Trainer Comments:_____

_____

Evaluator:_____ **Trainer:**_____
Print Name and Sign ***Print Name and Sign***

Original: Trainer
Canary Copy: Program Technical Director C/O OMHA OFFICE
Pink Copy: Evaluator

DT-2:05/09