COLORADO
Department of Early Childhood
Division of Early Care & Learning

HEALTH CARE WORKER ATTESTATION

PLEASE PRINT CLEARLY. COMPLETED FORMS MUST BE KEPT IN THE STAFF'S FILE AT CAMP.

Date: _____ Camp License Number: 47990

Health Care Worker Name & Title: _____

Camp Name: Twin Peaks Bible Camp

Camp Address: 9807 59 Rd

City: Collbran State: CO Zip Code: 81624

Licensed Physician/Registered Nurse Attestation Statement:

I, _____, attest as a Current Colorado Licensed Physician or Registered Nurse, that I will provide oversight to the Camp Health Care Worker as required by their scope of practice, during the following camp sessions that will run from _____ to _____.

Signature: _____

Title: _____

License #/Certification #: _____

Health Care Worker Attestation Statement:

I, _____, as a certified _____, attest that I am knowledgeable of the requirements of my scope and practice and I will ensure that I receive the required oversight and supervision from the above licensed Physician or Registered Nurse to operate as the Health Care Worker for Camp Twin Peaks Bible Camp. I attest that I will notify the Department within 48 hours of any changes to my certification, supervision, or oversight.

Signature: _____

License #/Certification #: _____