Continuing Education Training Record

Student Information

FIRST NAME	MIDDLE INITIAL	LAST NAME	DATE OF BIRTH (MM/DD/YYYY)

STREET ADDRESS OR PO BOX (LINE 1)	ADDRESS (LINE 2)

CITY	STATE/DISTRICT/PROVINCE	ZIP/POSTAL CODE	COUNTRY

PRIMARY PHONE NUMBER (MOBILE IS BEST)	E-MAIL ADDRESS

Course Information

COURSE NAME
STARTING DATE
ENDING DATE

Instructor 1

FIRST NAME	LAST NAME
PHONE (MOBILE IS BEST) (954) 792-4977	INSTRUCTOR NO.
EMAIL fun@aquaticventures.com	

Instructor 2

FIRST NAME	LAST NAME
PHONE (MOBILE IS BEST) (954) 792-4977	INSTRUCTOR NO.
EMAIL fun@aquaticventures.com	

Instructor 3

FIRST NAME	LAST NAME
PHONE (MOBILE IS BEST) (954) 792-4977	INSTRUCTOR NO.
EMAIL fun@aquaticventures.com	

Skill Development and Application

Skill	Date	Instructor Name or Number

Knowledge Development

eLearning Course Completed	Date
☐ SDI ☐ NASE ☐ PADI ☐ NAUI	

Instructor Statement: "On the date listed, this student met all requirements for academic knowledge development as required by standards.

Instructor Name _____ Instructor Number _____

Instructor Statement: "On the date(s) listed, this student met all of the requirements for skill application required by standards."

Instructor Signature _____ Instructor Number _____ Date _____

Student Statement: "I understand and have met all the requirements for certification."

Student Signature _____ Date _____