

CLA Course Attendance

Return this completed form within five working days from the course end.

Don't send the original - please keep a copy for your records

Provider Name:	
Provider Signature:	
Date:	Course Code:

Send (copy) to:
 13 Warrington Rd
 Harrow
 HA1 1SZ

or scan to:
 info@countrysideleaderaward.org

Candidates complete this section at start of course

Provider completes grey section at end of course

	First Name	Second Name	CLA Number or DOB	Signature	Completed Course?	Result (Assessment)
1					Yes No	
2					Yes No	
3					Yes No	
4					Yes No	
5					Yes No	
6					Yes No	
7					Yes No	
8					Yes No	
9					Yes No	
10					Yes No	
11					Yes No	
12					Yes No	

Other Staff

	First Name	Second Name	Qualification	MLTUK No or DOB	Signature
1					
2					