

# Training Request Form



Contact Name: \_\_\_\_\_ Agency: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Request: \_\_\_\_\_

Training/s requested: \_\_\_\_\_

Reason for request:  General interest in topic  
 Result of an Individual Review. If yes, please check the correct option below:  
 Person-centered training (individual's initials: \_\_\_\_\_ )  
 General training on subject matter  
 For staff who support an individual with this diagnosis/condition  
 Other: \_\_\_\_\_

Primary Audience  Direct Care Staff  Administrators/Supervisors  Support Coordinators  
 Individual/s  Other: \_\_\_\_\_

If requested around a particular individual, please share any information you think might help us tailor the training to better meet your needs.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How many sessions would you like?  One  Two  Multiple  
How long would you like the training/s to last:  30 minutes  1 hour  1.5 hours  2 hours  
 Other: \_\_\_\_\_

Days/time that work best for your staff:  
 Monday  Tuesday  Wednesday  Thursday  Friday  
 AM (preferred start time: \_\_\_\_\_);  PM (preferred start time: \_\_\_\_\_)

Number of Attendees expected: \_\_\_\_\_

(To be filled out by HCQU)

Date Scheduled: \_\_\_\_\_ Training Date: \_\_\_\_\_

Held as scheduled:  Yes  No Number who attended: \_\_\_\_\_

If no, why?  Weather  Fewer than 5 registrants  Emergency/Crisis Situation  Other

\_\_\_\_\_