

CHEMICAL DEPENDENCY TRAINING CONSORTIUM
OF THE NORTHWEST

AGENCY TRAINING WORKSHOP DATA SHEET

DATE OF TRAINING:

TITLE OF TRAINING: _____

LEVEL OF TRAINING: A B C

(SEE SECTION III, PAGE 1 FOR TRAINING LEVEL INFORMATION)

LOCATION OF TRAINING: Southwest Washington Medical Center's Memorial Campus located at 3400 Main St.,
Vancouver, WA 98663

SPONSORING AGENCY'S NAME: _____

AGENCY'S ADDRESS: ZIP: _____

AGENCY CONTACT PERSON: _____ PHONE: _____

GOAL OF TRAINING: _____

BEHAVIORAL

OBJECTIVES: _____

TRAINERS:

NAME _____ TITLE/DEGREE _____

NAME _____ TITLE/DEGREE _____

NAME _____ TITLE/DEGREE _____

(USE BACK OF SHEET, IF YOU HAVE MORE THAN THREE)

AUDIO-VISUAL EQUIPMENT NEEDS:

_____ FLIP CHART

_____ ERASE BOARD

_____ OVERHEAD

_____ SLIDE PROJECTOR

_____ VIDEO PLAYER

_____ MOVIE PROJECTOR

_____ SCREEN

OTHER _____

ABOUT THE TRAINER(S)

Please provide us with information about **each** facilitator for your training. *Make copies of this page for additional trainers.*
Please include the following:

Name: _____

Degree(s): _____

Certification(s): _____

Any experience, work or otherwise, he/she may have relating to the subject matter of the training:

Include any other trainings facilitated during his/her career:

Name: _____

Degree(s): _____

Certification(s): _____

Any experience, work or otherwise, he/she may have relating to the subject matter of the training:

Include any other trainings facilitated during his/her career:

Name: _____

Degree(s): _____

Certification(s): _____

Any experience, work or otherwise, he/she may have relating to the subject matter of the training:

Include any other trainings facilitated during his/her career:

TRAINING AGENDA: (USE ATTACHED EXAMPLES AS GUIDES)

TIMES TOPIC AND DESCRIPTION SPEAKER

9 am to _____

_____ to _____

(BREAK?) _____

_____ to _____

NOON to 1:00 pm LUNCH BREAK

TIMES TOPIC AND DESCRIPTION SPEAKER

_____ to _____

_____ to _____

(BREAK?) _____

_____ to _____

Mail or Fax to:

CDTC

ATTN: Kandis Hudson

PO Box 2603

Fax: (360) 666-6129

Email: <mailto:khudsoncdtc@yahoo.com>

COSTS/REFUNDS: \$50 Members; \$75 Non-Members; \$20 Students

KNOW YOUR MEMBERSHIP RESPONSIBILITIES

We understand that this Consortium is a cooperative effort among member-agencies, and that membership in the Consortium obligates member-agencies to provide approved training events. When member-agencies default on this obligation, the purpose of the Consortium is defeated. To discourage default, our RESOLUTION provides for sanctions.

The applicant shall defend, indemnify and hold harmless the Chemical Dependency Training Consortium of the Northwest from and against any and all liability, damages, claims, cost and/or expenses, including attorney fees, arising out of the content, presentation or facility used at the subject event.

The signature of applicant or contact person is required below.

I have read the guidelines for the CDTC recognition of training and will comply with all sponsor responsibilities as outlined.

Applicant or Contact Person Telephone No.

Title/Position _____

Date _____

CDTC

SECTION II
PAGE 5

PLEASE NOTE: We have received many incomplete applications. Every bit of information we request is important and vital to the establishment of our database. When you write, "see attached," in a column and we have to search for the answer, it may not be the correct answer. YOU, the applicant, need to supply the correct information to assure accuracy.

The staff of our member-agencies often depend upon Consortium events to meet their CEU obligations. The approval process for accreditation requires substantial lead time.

PLEASE MEET ALL DEADLINE DATES

RETURN TO:

Mail or Fax to:

CDTC

ATTN: Kandis Hudson

PO Box 2603

Fax: (360) 666-6129

Email: <mailto:khudsoncdtc@yahoo.com>