



The Counseling Team International
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TRAINING REQUEST FORM

Division: _____

Date	Training Requested	Location Contact Person Phone / Fax / Email	Address	Est. # Of Participant	***** Trainer Est. *****			Admin Clinician Approved
					Est. of Prep Time	Est. of Travel Time	Est. of Training Time	

*Notes: Local Training requires a Minimum of 10 participants
 Specialized Trainings requires a Minimum of 40 Participants*

Requesting Manager _____
 Printed

Requesting Area Clinician _____
 Printed