The Counseling Team International
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TRAINING REQUEST FORM

Division: _____

					****** Trainer Est. ******			
Date	**Training Requested**	**Location Contact Person Phone / Fax / Email**	**Address**	**Est. # 0f Particpant**	**Est. of Prep Time**	**Est. of Travel Time**	**Est. of Training Time**	**Admin Clinician Approved**

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

Requesting Manager_____ **Requesting Area Clinician _____**
Printed **Printed**