



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. # Of Participant	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 \_\_\_\_\_  
Printed

Requesting Area Clinician \_\_\_\_\_  
Printed