The Counseling Team International
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Rancho Mirage, CA 92270
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TRAINING REQUEST FORM

Training Date: _____ Requesting Area Clinician: _____

Training Requested: _____

Division: _____ Office/Lab: _____

Office Address: _____

Requesting Manager/Contact: _____ Phone number: _____

Estimated # of participants: _____

----------*TRAINER EXPENSE ESTIMATES*----------

Prep Time: _____ Estimated training time: _____

Estimated travel time: _____ Estimated mileage: _____ Estimated flight costs: $_____

Lodging needed?☐Yes ☐No If yes, how many nights: _____

For Office Use Only:

Per Diem: $_____

Travel Reimbursement estimate: $_____

Training estimate: $_____

Estimated total training costs: $_____

☐ Approved ☐ Denied By: _____ Date: _____