INSTRUCTIONS:
Thank you for your interest in training from TEACH. Please help us understand your training request better by completing this form.

Information about the organization(s) requesting training:
Date of request dd/mm/yyyy
Name of requesting organization
Name of partnering organizations, (if applicable)
Name of contact person
Contact information
   Email:
   Postal address:
   Tel.:
   Fax:

Nature of training required:
Goals and objectives of having training (purpose of the training)

Requested date of training:
   Exact date(s) required? □ If yes, specify: dd/mm/yyyy
   Or flexible date range? from to
   Comments:

Location of training:
   Town/city
**Audience profile:**

Estimated number of participants:

<table>
<thead>
<tr>
<th>Registration is:</th>
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<tbody>
<tr>
<td>Open to community (e.g., other agencies)</td>
<td>☐</td>
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<tr>
<td>Or Restricted:</td>
<td>☐</td>
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<tr>
<td>Please explain:</td>
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**Professional disciplines/roles (check all that apply):**

- Aboriginal Health Worker ☐
- Addiction Counsellor ☐
- Community Health Worker ☐
- General Practitioner/Family Physician ☐
- Health Educator ☐
- Nurse Practitioner ☐
- Pharmacist ☐
- Registered Nurse ☐
- Social Worker ☐
- Youth Worker/Advisor ☐
- Other, please describe:  |