St. Clair County Community Mental Health Authority

Staff Training Request

Supervisor to Complete (Please print)

Name: _____ Date: _____

Agency or Program: _____ Phone: _____

Training Topic: _____

Target Audience: _____

Number of Individuals Who Need This Training (if known): _____

Description of Training Request: _____

_____

_____

If known, who do you think will/can provide the training?

Trainer Name: _____

Phone: _____ E-mail: _____

Is this conference/workshop:

1. Mandatory Training (Training stipulated by regulatory bodies, as written in the applicable standards, rules and codes). Yes ☐ No ☐

2. Performance Improvement (Areas of improvement identified as a need by the supervisor from the Functional Job Task List and Evaluation). Yes ☐ No ☐

3. Skill Building (Training opportunities designed to expand or enhance current satisfactory job performance, skills or abilities, as related to the Functional Job Task List). Yes ☐ No ☐

Submitted by: _____ Date: _____

When complete, please submit to **Jodi Trombly** *jtrombly@scccmh.org*. Thank you.