St. Clair County Community Mental Health

Staff Training Request

Supervisor to Complete:

Employee Name: _____ Date of Request: _____

Agency or Program: _____ Phone Number: _____

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 Number: _____ Email: _____

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** (Area of Improvement identified as a need by the supervisor from the Functional Job Task List and Evaluation). ☐ Yes ☐ No
3. **Skill Building** (Training opportunity 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 Training Department Designee. Thank you.