COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – QUALITY ASSURANCE DIVISION
TECHNICAL ASSISTANCE TRAINING REQUEST FORM

TO BE COMPLETED BY REQUESTING PARTY

Requestor* Name: _____ **Title:** _____

*Must be Program Manager or higher

Contact Name: _____ **Tel. No.** _____

Program: _____ **Date of Request:** _____

Unique services provided by Program:

Proposed Title of Training: _____

Justification/purpose for training (Be sure to include why currently scheduled QA documentation trainings would not satisfy your training needs. Be specific regarding special topics, issues, locations, staff.):

Proposed Audience:
☐ Clinical Staff ☐ Non-Clinical Staff ☐ Clinical & Non-Clinical Staff
☐ Other _____
☐ Directly-Operated Staff ☐ Contract Provider Staff ☐ DO & Contract Provider Staff

Expected # of Attendees: _____ **Preferred Location:** _____

Suggested Date(s) of Event: _____

Program Manager or higher level staff:

Print	Signature	Date
_____	_____	_____

For further information contact: **Quality Assurance Division** Tel. No. (213) 251-6855	**Return completed form by e-mail:** **E-mail: QA@dmh.lacounty.gov**

TO BE COMPLETED BY QUALITY ASSURANCE

Date Received: _____ **Staff Receiving:** _____

Disposition:
☐ Approved (QA Training) ☐ Referred to Training Division (Not a QA Training)
☐ QA Training is not appropriate ☐ Other: _____

Comments:

Date of Notification to Requestor: _____

Assigned Training Coordinator: _____

Assigned QA Staff: _____

Date: _____ **Location:** _____

Revised: 09/2012