



## SELF-MANAGEMENT PROGRAMS -- OFFSITE GROUP MASTER TRAINING REQUEST

PLEASE FAX THIS FORM TO 650.725-9422 -- Attention Sonia Alvarez

1

**CHECK THE PROGRAMS YOUR TRAINING WILL COVER AND TYPE OF TRAINING BASED ON DURATION** *(Cross-trainings require trainees to be certified Master Trainers in CDSMP, Tomando, Diabetes English or Diabetes Spanish. Available combos: CDSMP/DSMP or Tomando/Manejo Personal de la Diabetes ):*

Full Training (4.5 days)	Cross-Training (1-2 days)	
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Disease Self-Management Program (CDSMP)
<input type="checkbox"/>	<input type="checkbox"/>	Tomando Control de su Salud (Tomando)
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Self-Management Program (DSMP)
<input type="checkbox"/>	<input type="checkbox"/>	Manejo Personal de la Diabetes (SDSMP)
<input type="checkbox"/>	<input type="checkbox"/>	Positive Self-Management Program (HIV)
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis Self-Management Program (ASHP)
<input type="checkbox"/>	<input type="checkbox"/>	Curso de Manejo Personal de la Artritis (Spanish ASHP)
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pain Self-Management Program (CPSMP)

2

**CHECK THE TYPE OF TRAINING YOU ARE REQUESTING BASED ON COORDINATION LEVEL**

- Stanford-Sponsored Training** (Coordinated by Stanford. T-Trainers will be recruited) (\$10,000 training fee)
- Non-Stanford Sponsored Training** (Coordinated by your own T-Trainers) (\$4,000 fee) Please provide the names of T-Trainers employed / affiliated to your organization:

\_\_\_\_\_ and \_\_\_\_\_

3

**SPECIFY TRAINING DATES (Please provide 2 possible dates for Stanford Sponsored Trainings):**

\_\_\_\_\_ or \_\_\_\_\_  
Preferred Alternate (Stanford-sponsored trainings only)

4

**PROVIDE:** Legal Name of organization hosting the training (This will appear in written documents)

\_\_\_\_\_

Mailing address: \_\_\_\_\_

Contact person (main contact person coordinating this training) \_\_\_\_\_

Phone No.: (     ) \_\_\_\_\_ Fax No.: (     ) \_\_\_\_\_

E-mail address: \_\_\_\_\_

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**Location of training if different from location of hosting organization:** \_\_\_\_\_

- Yes, I checked the website (<http://patienteducation.stanford.edu>) for license and training fees.**

Is this training open to others outside your local area who wishes to attend?  Yes  No Training Fee: \$ \_\_\_\_\_