



Combined Parent Child Cognitive Behavioral Therapy Training Request

The CARES Institute provides clinical training in Combined Parent Child CBT depending upon the availability of trainers/clinicians. For consideration, please complete this form and return to davisno@umdnj.edu or fax 856-566-2778.

Date: _____ Agency: _____

Street Address: _____

City: _____ State: _____ Zip: _____ If other than US, country: _____

Contact Person: _____ Phone #: _____

Email address: _____ Fax: _____

How many years has this agency been serving children who have experienced trauma or physical abuse? _____

Is this agency a member of or affiliated with the National Child Traumatic Stress Network? ____ Yes ____ No

If yes, please explain affiliation. _____

Has your agency received training from the CARES Institute ? ____ Yes ____ No

If yes, please explain. _____

Type of training requested (check all that apply): ____ Overview ____ Introductory Clinical ____ Advanced Clinical

Number of days (see informational sheet for ranges): ____ Overview ____ Introductory Clinical ____ Advanced Clinical

Possible dates for training (if known): _____ Total number to be trained: _____

Closest airport to agency: _____ Suggested hotel: _____

If the request is only for clinical training (not for consultation services), a formal contract may not be required. Is your agency willing to execute a confirming letter rather than a formal contract? ____ Yes ____ No

If requesting post-training consultation services, how often: ____ weekly ____ bi-monthly ____ monthly ____ other

Consultation services will last for how long: ____ 3 months ____ 6 months ____ 12 months ____ other

Thank you for your inquiry. You will be contacted within 2 weeks about this request.

DO NOT COMPLETE - Internal Use Only

Date to MR: _____ Date Approved: _____ Assigned Trainer: _____ Date to MLS: _____

Date to RW: _____ Date Confirming Letter received: _____ OR Date contract sent to legal management: _____