

TRAINING APPROVAL/CONFIRMATION FORM

Please complete this form and provide to your supervisor at least two weeks prior to the start of the training you plan on attending.

NOTE THAT PRE-APPROVAL IS REQUIRED PRIOR TO REGISTERING FOR ALL TRAININGS.

Please keep a copy for your files and upload to MyPCTI Online. For external trainings that do not provide certificates of completion, supervisors can use this form to provide confirmation that the training has been completed by their staff.

First Name: <u>Beth</u>	Last Name: <u>Jenks</u>
Job Title: <u>Corporate Director of Clinical Training</u>	Program/Site: <u>Clinical Intern Training Department</u>
Divisional Director: _____	Division: _____
Supervisor Name: <u>Scott Fairhurst</u>	

What is your primary reason for attending? (Select box below)

- Required for license/license renewal
- Required for management/professional development
- Required Culturally Responsive training
- Mandatory training
- Other (Specify) _____

Please list Training(s)

1 **Training Name:** Lesbian and Bisexual Women's Health Train-the-trainer Workshop
Training Provider: LA County Lesbian & Bisexual Women's Health Collaborative

Date: June 7, 2019 **Time:** 1 to 4 pm **# of Hours:** 3 **Location:** CA Hospital Medical Center, Los Angeles, 9001

Pacific Clinics Training Pacific Clinics Webinar
 Non-Pacific Clinics In-Person Training Non-Pacific Clinics Webinar Non-Pacific Clinics self-paced online module

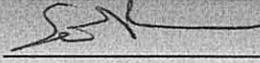
2 **Training Name:** _____
Training Provider: _____

Date: _____ **Time:** _____ **# of Hours:** _____ **Location:** _____

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 Non-Pacific Clinics In-Person Training Non-Pacific Clinics Webinar Non-Pacific Clinics self-paced online module

Please use a new form to list additional trainings.

Supervisor Use Only

Request Approved: 1 2 3 **Supervisor Signature:**  **Date:** 6/23/19
Supervisor Notes: _____

External Training Completion Confirmation (in lieu of Certificate of Completion)

Training Completed: 1 2 3 **Supervisor Signature:** _____ **Date:** _____
Supervisor Notes: _____