**Chronic Disease Self-Management “UPDATE” Leader Training**

Application Form

**1. Program Licensure**

In order to participate in this training, you must be affiliated with an organization that is licensed by Self Management Resource Center (SMRC) to deliver the Chronic Disease Self-Management Program (CDSMP). Please indicate your organization’s status below.

My organization holds a current Chronic Disease SMP license: Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My organization is partnering with an organization that holds a current SMRC CDSMP license, a letter of agreement describing our partnership is attached to this application. Organization Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

My organization has applied for a SMRC CDSMP license and expects to complete paperwork before the leader training. Date to be completed: \_\_\_/\_\_\_/\_\_\_\_

For detailed information regarding program licensure, please visit <https://www.selfmanagementresource.com/licensing/licensing-procedure-policies/> or contact the Self Management Resource Center at 1-650-242-8040 Ext 406. Please note that training cannot be provided to individuals who are not affiliated with a licensed organization.

**2. Organizational Questions (to be filled out by the representative from the organization under which the leader will operate)**

Please answer the following questions about your organization.

1. How does **CDSMP** fit into your organization’s long-range plans for supporting people with chronic conditions in your community?
2. Describe staff roles within your organization and how staff can dedicate time to promote and coordinate **CDSMP** programs twice a year, and support lay leaders (community volunteers).

3. Newly trained Leaders should deliver their first program within 2-6 months of this training. Please indicate the date and location for the first program your newly trained Leader(s) will be involved in leading. Date: \_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sponsoring Agency signature Title Date

**3. Applicant Information (please duplicate this page as needed)**

Name of Leader applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Leader Training you are applying for? Class Type: **CDSMP Leader Update 2020**

**Location**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a Lay Leader (non health/social service professional)? Yes\_\_\_\_ No \_\_\_\_\_

Are you living with **chronic conditions**? Yes \_\_\_\_ No \_\_\_

Have you attended a Living Well program as a participant? Yes \_\_\_ No \_\_\_\_

Sponsoring Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Title/Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Briefly describe your interest in participating in this program.
2. Do you anticipate any barriers to leading two workshops a year (work or family obligations, transportation, health, etc.)? If yes, please explain.

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Applicant Signature Title Date

Accommodations requested:

Sign language interpreter

FM System (for hearing impairment)

Wheelchair-height tables

Large print training materials

Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please email completed applications to Lavinia Goto at** [**Lavinia.goto@nwsds.org**](mailto:Lavinia.goto@nwsds.org) **OR Fax to: 503-304-3465 Attn: Lavinia Goto**