



Stanford Patient Education Research Center

1000 Welch Road, Suite 204 · Palo Alto CA 94304
<http://patienteducation.stanford.edu> · (650) 723-7935

Print this completed application and mail WITH PAYMENT and attached master trainer sheet to the address above

Application Self-Management Program Master Training

NOTE: You must submit an additional different application if you want cross-training

I wish to attend the following training *(All are tentative, based on venue and enrollment):*

Nov 30 – Dec 4, 2009 – CDSMP
Jan 11-15, 2010 – Tomando
Feb 8-12, 2010 – CDSMP
Apr 6-10, 2010 – CDSMP

Jun 22-26, 2010 – CDSMP
Aug 23-27, 2010 – CDSMP
Nov 15-19, 2010 – CDSMP

First Name:

Last Name:

Representing:

Address: Home Work

Phone:

Fax:

E-mail:

I have a chronic health problem. (please specify):

I am a health professional. (please specify):

Enclosed is (tuition **MUST** accompany application to confirm registration).

\$1600 TUITION in full (health professional)

\$900 TUITION in full (lay person with chronic disease)

I need parking permits for the following days at \$12.00 per day (must purchase in advance):

Mon Tues Wed Thurs Fri

TOTAL ENLCOSED, made out to STANFORD UNIVERSITY:

NOTE: This amount does NOT include your organization's license. You must also submit a license form and fees.

SPECIAL REQUESTS:

Dietary requests: Vegetarian Diabetic Other (specify):

Disability accommodations (specify):

I wish to register for this training and I certify that the above information is correct.

TRAINEE'S signature *(must be signed ONLY by TRAINEE)*

Date

APPLICATION DEADLINE (with FULL tuition) 3 weeks prior to training date! Training is limited to 26; first come, first served. No refunds after the deadline (refunds only if class cancelled by Stanford). Do NOT make travel arrangements until you receive a confirmation from us.



**SELF-MANAGEMENT PROGRAM INFORMATION
TO BE COMPLETED BY MASTER TRAINEES ONLY**

SECTION 1. TRAINING INFORMATION

Site where training held:

Dates of training:

Training was for which Program(s):	CDSMP	Tomando Control de su Salud
	English Diabetes	Spanish Diabetes
	PSMP (HIV)	Pain

Is your organization currently licensed to offer the Program(s)?	No	Yes	(date of license: month & year)
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SECTION 2. MASTER TRAINER INFORMATION: This information will be entered into our database as your contact information.

Name:

Organization:

Mailing Address:

Home
Work

Phone No:

Fax No.:

Email:

ALTERNATE ADDRESS:

Mailing Address:

Home
Work

Phone No:

Fax No.:

Email:

Have you taught this program as a leader? No Yes Number of workshops:

<p>IMPORTANT NOTICE</p> <p>Upon satisfactory completion of training you will receive a Master Trainer Authorization Agreement. The agreement certifies you to train leaders but certification does not go into effect until you have met all requirements set forth in the agreement.</p>
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