



# 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  
**FAXED APPLICATIONS NOT ACCEPTED!**

## Application Combination Tomando Control de su Control/Diabetes Spanish Chronic Disease/Diabetes Self-Management Programs Master Training

I wish to attend the following training:

July 7 - 11, 2008

First Name:

Last Name:

Representing:

Address:                      Home                      Work

Phone:

Fax:

E-mail:

I speak and read Spanish fluently **(required)**

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

I am a health professional. (please specify):

Enclosed is (you will NOT be registered until FULL tuition is received).....

\$1500 TUITION in full (health professional)

\$800 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 ENLCOSSED, made out to STANFORD UNIVERSITY: .....

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

### 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!**  
**Do NOT make travel arrangements until you receive a confirmation from us.**



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

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**SECTION 1. TRAINING INFORMATION**

Site where training held:

Dates of training:

Training for which Program(s):      CDSMP  
Tomando Control de su Salud (Spanish Chronic Disease Self-Management)  
Tomando Control de su Diabetes (Spanish Diabetes Self-Management)  
PSMP (HIV)

Is your organization currently licensed to offer the Program(s)?      No      Yes  
(date of license: month & year)

**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:

**IMPORTANT NOTICE**

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.