

**Training Request Form**

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| **REQUEST DATE**        |
| **YOUR ORGANIZATION** |
| Organization Name:        | Contact Email:        |
| Contact Name:        | Contact Phone:        |
| Organization/Program Description:        |
| Organization Address:        |
| **TRAINING MODULE** *(Select one below)* |
| [ ]  **Parent and Caregiver Training** | [ ]  **Provider Training** |
| Training Location (Full Address):        |
| Training Date:        | Training Start Time:        |  Est. Number Attendees:        |
| **AVAILABLE EQUIPMENT** |
| Laptop (Y/N):        |  Projector (Y/N):        |
| **TARGET AUDIENCES** |
| Professional Staff (Y/N):        | Faith-Based Group (Y/N):        | Parents/Caregivers (Y/N):        |
| Parenting Teens (Y/N):        | Other, please describe        |
| **Please return this completed form to:** CFWB.NYCInfantSafeSleepInitiative@acs.nyc.gov**NOTE:** Training requests should be made AT LEAST two weeks prior to your event.Allow 2-3 business days for event confirmation. |