A picture containing monitor, screen, sitting, television

Description automatically generated

**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](mailto: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. | | | | | |