Workshop Request
(Agency)

In order to meet the needs of your agency, please provide the following information in a timely fashion. **Please note that the requested workshop will not be confirmed until Autism New Jersey staff has sufficient information to determine if we can meet your training needs.**

1. Name of agency: ____

2. Address: ____

3. Phone number: ____

4. Contact person: ____

5. Possible workshop dates (*not set until confirmation): _________________________

6. Does your agency receive funding from the New Jersey Division of Developmental Disabilities (DDD)? YES / NO

7. What is the requested topic?

8. Please list a minimum of 3 objectives you would like your staff to learn from this training. In other words, what are your goals for your staff as a result of this?

OFFICE USE ONLY

Snt ______ Rcd ______ Dec ______ FFS? ______ Rpt ______ Prs ______ Pd ______

9. What is the estimated number and type of audience (e.g., direct care workers, administrators, supervisors, medical professionals)?

10. Please describe the level of knowledge and skills with respect to autism and behavioral programming among the identified staff.

11. Does your agency have an identified lead for behavioral programming? YES / NO

(a) If yes, does s/he have current BCBA or BCaBA certification status? YES / NO

(b) If BCaBA, who is supervising him/her?

(c) If not BCBA or BCaBA, please describe practical behavior analytic experience.

(d) How much time does that professional typically commit to the identified classroom or student?

12. How will concepts and skills presented in the workshop be followed up on and integrated into your program?

13. Please describe your agency (e.g., age of clientele, disability, functioning level, staffing ratio, programs/therapies offered). Also, what are typical teaching approaches/methods used in your agency?

14. Additional Information:

Please initial to show your agreement with the following statements:

______ Attendance at an Autism New Jersey workshop does not constitute endorsement or certification of the agency's program, nor does it represent a determination of the receiving agency's competency in the areas of autism or applied behavior analysis. No such claims should be made.

______ The agency acknowledges that if Autism New Jersey determines that the needs of the agency are not compatible with Autism New Jersey's mission or within the scope of services provided by Autism New Jersey, Autism New Jersey reserves the right to terminate consultation. Autism New Jersey will communicate this via telephone and in writing.

______ The agency shall indemnify and otherwise ensure that Autism New Jersey, Inc., its Board of Trustees, and its representatives are held harmless for any damages or injury which may occur during or subsequent to the workshop.

______ In the event that a presentation must be canceled, the agency will notify Autism New Jersey with a minimum of 24 hours notice.

Thank you for your time in completing this form thoroughly so we can determine if we can fulfill this request. Please return it to Elizabeth Neumann, BCaBA via e-mail, fax, or mail.

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