

Data Collection Training Request Form



Lead Contact Name:	Tele#	Email:
List all your agency's sites that are/will be participating in Treat First: (Insert more if needed)	Medicaid ID	NPI
Name/location of Facility Site		
Name/location of Facility Site		
Name/location of Facility Site		
Name/location of Facility Site		
When are you requesting that your staff be trained on the data collection system?	Proposed dates	
Number of staff attending training	#	
Signature: _____ Name and Title: _____ (Print please) Email: _____ Date: _____		

Send completed form to support@bhsdstar.org