RE-Certification

Data Collection Training Request Form

Agency Name: 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:______________________ Telephone Number:_________
Date:__________________

Send completed from to support@bhsdstar.org