### Training/Presentation Request

**UF Jacksonville CARD  *  UF Jacksonville FDLRS – MDC**

*6271 St. Augustine Road Suite 1, Jacksonville, Florida 32217*
*(904) 633-0760 (CARD)  *  *(904) 633-0750 (FDLRS-MDC)*
*(904) 633-0817 Fax*

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**Date of Request:** ______________________  **Requestor’s Name:** ______________________

**Agency Affiliation:** ________________________________________________________________

**Phone:** (____) ___________________________  **Fax:** (____) ___________________________

**Requestor’s Email Address:** _______________________________________________________

**Subject Requested / Title of Training or Presentation (if known):**

______________________________________________

**Requested Date(s) and Time(s):** ____________________________________________________

**Proposed Length or Time Allotted for Training/Presentation:**

______________________________________________

**Proposed Intensity of Training/Presentation (check one):**

_____ Awareness  _______Familiarity  _______Competence

**Level of Audience Knowledge (check all that apply):**

_____ Newly Involved  _____ Intermediate

_____ Advanced (Non-Supervisory)  _____ Advanced (Supervisor-Train-the-Trainer)

**Type of Audience (Family Member, Service Provider (Type/Specialty), Educator (Grades/Setting)):**

______________________________________________

**Number of Attendees/Participants:** _________

**Closed to the Public**  or  **Open Registration (circle one):**

**Proposed Format (check one):**

_____ Lecture  _____ Workshop  _____ Make & Take  _____ Presentation / Q & A

**Location of Training/Presentation:** (Notate if you would like to use the UF Health Developmental Pediatric Center’s Conference Room)

______________________________________________

**Would you like us to help advertise this event by posting it on Eventbrite?:**  YES  NO

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**To Be Completed by UF Jacksonville CARD / UF Jacksonville FDLRS-MDC Office:**

**CARD/FDLRS-MDC Staff Member Receiving the Request:** ______________________

**Training/Presentation Assigned to:** ______________________ on (date) ______________________

**AV Equipment Required:** ______________________ on (date) ______________________

**AV Equipment Reserved by:** ______________________ on (date): ______________________

**Signature of Director/Lead Clinician:** ______________________

**Signature of Presenter:** ______________________

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**Requestor:**

*Fax this completed form to Elise Summa, Lead Clinician, and a staff member will contact you to discuss/schedule your training/presentation. Please submit all forms at least 2 weeks prior to the requested dates.*