Community Prevention Training System (CPTS) Application

Please refer to the 2003-2005 CPTS Guidelines as you complete this application.

Reminder: We need to receive your application at least 60 days in advance of the training. If there are any subsequent changes to the application after it has been submitted (e.g. the training is postponed), you must notify us immediately.

Individual Applicant's Name:_____

Organization Name (if applicable):_____

Address:_____

City & Zip Code: _____

Phone/Fax/Email:_____

1. **Training Date(s) and Location:** (*When/where will the training take place?)*

   Date(s) of Training: _____
   Location of Training: _____
   Trainers Name:_____
   If applicable, copy of training/seminar brochure attached: ☐**Yes** ☐**No, please explain:**_____

2. **Is the training you are applying for listed as one of the Center for Substance Abuse Prevention's (CSAP) Best Practice or Promising Approaches, specifically, listed on the website at** http://casat.unr.edu/westcapt/bestpractices/alpha-list.php

   ☐ **If yes, attach the copy of the Best Practice or Promising Approaches page from the previous link listed above and name the CSAP Best Practice or Promising Approach:**
   - ❑ **Copy attached of the Best Practice or Promising Approach**
   - ❑ **Name of Best Practice or Promising Approach:**_____

   ☐ **If no, then:**
   - ❑ **Name of Training:**_____
   - ❑ **List the CSAP "Principles of Substance Abuse Prevention" (see link above – Carol, I would put the specific link to the pages of their WestCAPT website):** _____
   - ❑ **List the CSAP Best Practice or Promising Approach programs that were considered:** _____

- ❑ **Briefly describe/explain why you did not choose a training in one of the CSAP Best Practice or Promising Approach programs:**

  _____

  _____

5. **How many people will be trained if the application is approved, who will receive the training, and who is the trainer(s)?** (How many people are you sending to the training/seminar? Or, if bringing in a trainer, how many people will receive training as a result of this application?).

   How many people to be trained:_____
   Who will be trained?_____
   Name(s) of the trainer(s):_____

6. **Total project cost:** (List the <u>total</u> amount the training will cost, including <u>all funds</u> that support this training event. **Must have at least 10% matching funds**).

Itemized Expenses	CPTS Grant Amount Being Requested	Matching Funds
Registration Fee		
Lodging		
Meals		
Transportation		
Other Matching Funds		
TOTALS		

7. **Are these costs in compliance with CPTS guidelines?** (Please refer to the attached 2003-2005 CPTS guidelines).

   ☐ **Yes** ☐ **No, please explain:**_____

8. **Who will <u>prepaying</u> for this training?** (Note: *In addition to this application, a King County contract may be required or approval may need to be obtained from other King County departments*).

   ☐ **Agency Contract** ☐ **Individual (only for Registration Costs)**

Mail Application To: Carol Jernigan
Public Health – Seattle & King County
Alcohol & Other Drug (AOD) Prevention Program
400 Yesler Way, Suite #300
Seattle, WA 98104

Or Email Application To: Carol.Jernigan@metrokc.gov
Or Fax Application To: (206) 205-8638

This section for AOD Prevention Program use only	
Date Received:	☐ Approved ☐ Not Approved
Modifications, if necessary:	
Approval Signatory: Date:	Maximum Expenditure: $
Supervisory Signature:	