Living Well With Chronic Conditions

(Chronic Disease Self Management Program)

Application for Program Leader Training

Name:	Title:	Phone Number with Area Code:
Sponsoring Agency Name:	Sponsoring Agency Address:	City and Zip Code:
E-Mail: Fax Number:		

1.) What county (or counties) does the sponsoring agency serve?

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2.) Are you an employee of the sponsoring agency? Yes No

3.) Does your sponsoring agency have a license through Stanford University to offer this program? Yes No

4.) Do you have a chronic health condition or disease (circle one)? Yes No

5.) Are you applying to be a lay leader (non-employee volunteer)? Yes No

6.) Since the 6-week sessions need to be taught in pairs, we recommend having a partner from your agency to pair with. If you have a partner in mind, please list that person's name here: (*If you need a partner, we may be able to pair you with someone.)*

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(Please be sure that the person you listed above also sends an application for the Class Leader Training if he/she is not already a Class Leader.)

7.) **AGREEMENT:** I agree to facilitate the program exactly as outlined as according to the script, without deviation. I agree to schedule and facilitate at least one (1) participant workshop within 1 year of the completion date of my Leader Training. I understand that if I do not follow this agreement, my agency may be held responsible for reimbursing the State of Wisconsin, Bureau of Aging and Disability, for the costs associated with my training provided through this project. If I do not follow the script, I understand that my ability to facilitate this program may be in jeopardy.

Signature: ___________________________________ Date: _________________________________

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