

TRAINING NOTIFICATION FORM

Approved Providers must submit notification of all programs at least thirty (30) days prior to each program. This form must be submitted to TCBAP. No other notification will be accepted. Please make copies of this form for future use.

PROVIDER INFORMATION

Provider Name (as it appears on provider certificate)

Provider Number

PROGRAM INFORMATION

Program Title

Program Address (including city and state)

Program Instructor(s)

Program Date(s)

Program Time(s)

Brief description of program content:

Will this program be advertised? YES NO

Will this program be open to all professionals? YES NO

PLEASE CATEGORIZE HOURS AS FOLLOWS:

_____ General Education Credit Hours
_____ Ethics Credit Hours
_____ Clinical Supervision Credit Hours
_____ Cultural Awareness Credit Hours
_____ Dual Diagnosis Credit Hours
_____ Prevention Credit Hours
_____ HIV/STDs/HEP-C
_____ CCJP

_____ **TOTAL CREDIT HOURS OFFERED FOR THIS COURSE**

MAIL/FAX/EMAIL THIS FORM TO:

TCBAP, 1005 CONGRESS AVENUE, STE. 460, AUSTIN, TX 78701
FAX: (512) 476-7297 * EMAIL: TCBAP@TCBAP.ORG

FOR OFFICE USE ONLY

Date received: _____

Fee Received: YES NO

Fee Amount: _____

Payment Information: _____

Reviewed by: _____

Date: _____