No Wrong Door Integrative Screener
Training Request Form

Agency Contact Providing this Information

Contact Name: ____________________________  Phone: ____________________________  Fax: ____________________________
Email: ____________________________

Agency Name: ____________________________________________________________________
Specific Department/Division (if applicable): __________________________________________
Agency Location: __________________________________________________________________

What types of providers work within your agency/program? (check all that apply)

- □ Physician
- □ Nurse
- □ Social Worker
- □ Mental Health Counselor/Clinician
- □ Substance Abuse Counselor/Clinician
- □ HIV Counselor
- □ Case Manager
- □ Outreach Worker
- □ Other (specify): ____________________________

In what context do these providers see clients? (check all that apply)

- □ Medical Care
- □ Mental Health Treatment
- □ Substance Abuse Treatment
- □ HIV Counseling
- □ HIV Testing and/or Treatment
- □ Case Management
- □ Outreach
- □ Other (specify): ____________________________

Does your agency have existing services or referrals in place for each of the following referral needs identified by the NWD Integrative Screener? (check all services/referrals you currently have)

- □ Primary/Medical Care
- □ Mental Health Treatment
- □ Substance Abuse Treatment
- □ Tobacco Cessation Services
- □ Sexual Risk Reduction Counseling
- □ Sexual Health in Recovery (Sexual Health Programming)
- □ HIV Medical Care/Treatment Adherence Support
- □ HIV & Other Infectious Disease Testing & Counseling
- □ Case Management

What types of clientele does your agency serve? ____________________________________________
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Briefly explain your goals and expectations for this training:

Total number of providers to be trained to use the NWD Integrative Screener: ______

Proposed day(s)/date(s), and time(s) for training: ______________________________________

Note: Training for providers who will be screening clients using the NWD Integrative Screener is conducted in a 3hr. period.

Additional Details to Consider
• Trainings are typically held at your agency location. If you are interested in having your training hosted at a location outside of your agency, please let us know.

• CEUs will be awarded (up to 3 credit hours) for attendees who complete the training, and will be mailed to participants following completion of the training.

Please email (ccc.umbc@gmail.com) or fax (410-455-3866) this completed form to the Center for Community Collaboration.

If you have any questions or concerns, please contact us using the information below.

Center for Community Collaboration
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University of Maryland, Baltimore County
1000 Hilltop Circle
Baltimore, Maryland 21250
P: 410-455-5840
F: 410-455-3866
ccc.umbc@gmail.com
http://centerforcommunitycollaboration.org