

LIVE LIKE YOUR LIFE DEPENDS ON IT

**Application for Chronic Disease Self-Management
Program Leader Training**

1. Name _____ 2. Birthdate _____
(OPTIONAL)
3. Address _____
City _____ State _____ Zip _____
4. Telephone: Home: _____ Work _____
5. E-mail address _____ Cell Phone _____
6. What is your educational background/degree(s)? _____
7. What other relevant education/course work have you had? _____

8. What is your profession? _____
9. Where are you employed? (name/address) _____

10. What is your position/title? _____
11. Will the course be offered as part of your agency service (job duties)? YES NO
Will it be offered with you participating as a private individual or community volunteer? YES NO
12. Check current training or certifications and indicate date trained if known:
- Arthritis Foundation Self Help Course Leader _____
 - Arthritis Foundation Exercise Program Leader _____
 - Chronic Disease Self-Management Program Leader _____
 - CPR _____ (valid to _____)
13. Describe your experience working with: people with chronic diseases, diabetes, heart disease, respiratory problems, people with disabilities or other special populations.

