ATTACHMENT I

FUNDING SOURCE:

Unit Code: _____
Project Code: _____

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
OUTSIDE TRAINING REQUEST (OTR)

Complete this form to request authorization to attend outside training. *Without a purchase order, the Department will not be liable for registration fees for employees that registered directly with outside trainers/vendors.* Incomplete/Inaccurate forms will be returned to the appropriate Bureau Analyst.

Indicate the Type of Outside Training Request:	**NOTE:** Outside Training Request must:
☐ ***Clinical*** (Trainings identified as one that will enhance clinical skills). – Submit to the DMH Training Unit, 510 S. Vermont Ave, 17th Floor, Los Angeles, CA 90020. ATTN: Outside Training Request. Email to: *DMHTrainingUnit@dmh.lacounty.gov* ☐ ***Non-Clinical*** (Trainings identified as one that will enhance administrative/technical skills). Submit to DMH Training Unit, 510 S. Vermont Ave, 17th Floor, Los Angeles, CA 90020 ATTN: Outside Training Request. Email to: *DMHTrainingUnit@dmh.lacounty.gov*	1) Include approval by the employee's supervisor/manager, Bureau Budget Analyst, and Deputy Director; 2) Completed and submitted consistent with DMH Policy/ Procedure No. 614.03; 3) Identify funding source; and 4) Submit to the DMH Training Unit at least 6-8 weeks prior to the date of the scheduled training. It is the responsibility of the employee and the respective management to properly complete and submit all forms in a timely manner.

DATE OF REQUEST: _____ EMPLOYEE NAME: _____

EMPLOYEE # _____ PAYROLL TITLE: _____

WORK ADDRESS: _____ PROFESSIONAL LICENSE # _____

TEL.#: _____ E-MAIL: _____ FAX # _____

BUREAU: _____ DIVISION/PROGRAM: _____

Note: If you are traveling **outside the County of Los Angeles** for this training, you must submit a **Travel Request via Service Catalog** http://servicerequest.dmh.co.la.ca.us. (Policy/Procedure No. 900.01)

TITLE OF TRAINING: _____

LOCATION OF TRAINING: _____

DATE(S) OF TRAINING: _____

TRAINING VENDOR & VENDOR #: _____

Note: Employees are responsible to pay for the cost of Continuing Education (CE) or Continuing Education Units (CEUs)

JUSTIFICATION: Please describe below how the Department will benefit from your attendance at the training. ***"See Brochure" or "See flyer" is not acceptable as justification.*** The brochure, flyer, or informational bulletin must be attached to this request.

_____

_____

REGISTRATION FEE $ _____

Employee Signature	Employee Name (Print)	Date
Supervisor Signature	Supervisor Name (Print)	Date
Division Analyst Signature	Division Analyst Name (Print)	Date
Administrative Liaison Signature	Administrative Liaison Name (Print)	Date
Administrative Deputy Signature	Administrative Deputy Name (Print)	Date Approved

THE SECTION BELOW TO BE COMPLETED BY THE DMH TRAINING UNIT

Request for funding is: Approved ☐ Denied ☐

_____
Signature

Date Approved