THE STANFORD CHRONIC DISEASE SELF-MANAGEMENT PROGRAM

BETTER CHOICES, BETTER HEALTH

Application for Group Leader

Please read the qualifications listed on flyer and complete this application if you are interested in being a leader. I wish to attend the leader training that will be held:

Month: **Dates:** **, 2015**

Please Print Legibly

Name: Birth Date:

Address:

City: State: Zip: County:

Phone Number: Home Work Cell

Preferred Email Address:

Do you have an ongoing (chronic) health condition? Yes No

Host Organization (Organization that is sponsoring you to offer Better Choices, Better Health):

Name:

Address:

Phone Number:

Primary Implementation Site (where you will be offering the workshops):

Name:

Address:

Phone Number:

What is your educational background?

Describe your experience working with older adults, people with disabilities, or other relevant experience?

Describe any experience as a teacher, leader, or trainer:

Describe any other relevant experience: ____

____

____

Are you available to co-lead the six-week workshop at least twice a year? Yes ___ No____

Please describe the site where you intend to conduct the Chronic Disease Self-Management Program (check appropriate box):

	Yes	No
Handicapped accessible entrance		
Handicapped accessible parking		
Handicapped accessible exercise room		
Handicapped accessible bathroom		
Room large enough to enable easy movement for 12 people		
Sturdy chairs that are easy to get in and out of		

Program Location/Facility Name ____

Address: ____

Phone Number: ____

Please submit completed application by ____________ , 201 __ to:

SC DHEC
Attn: Arthritis Program Coordinator
2600 Bull Street
Columbia, SC 29201

Phone: (803) 898-9578
Fax: (803) 898-0350, Cell: (803) 383-1883
E-Mail: williapd@dhec.sc.gov

CHRONIC DISEASE SELF-MANAGEMENT PROGRAM GROUP LEADER AGREEMENT FORM

As a Chronic Disease Self-Management Program Group Leader, I ______________________________
(PRINT NAME)

________________________________ of ____
(ORGANIZATION NAME)

agree to conduct the program as set forth in the Chronic Disease Self-Management Program (CDSMP) Leader Manual. I understand that I must be present for all 4 days of the training and successfully complete all training activities. Within 3 months of completing the training, I agree to offer a workshop (once a week for 6 weeks) for my organization and at least one more 6-week workshop within 12 months of the training date. Following the successful completion of the second workshop series, I may apply to become a Certified CDSMP Leader. I understand that I must maintain this certification while serving as a leader. I agree to continue to offer the program over time and commit to co-leading 2 workshops per year. I have my organization's commitment to make this a part of its regular programs and/or services.

____ ________________________
APPLICANT'S SIGNATURE DATE

AGENCY APPROVAL

Approval is given for ____ an
Print Name

employee/volunteer of ____
Agency/Organization Name

to be trained as a facilitator and to implement the Better Choices, Better Health Chronic Disease Self-Management Program in accordance with the guidelines above on behalf of our agency.

____
(PRINT NAME AND UNDERLINE TITLE) - AGENCY DIRECTOR / EMPLOYEE'S SUPERVISOR / VOLUNTEER COORDINATOR

____ __________________________
SIGNATURE DATE