

**Cabinet for Health and Family Services  
Non-State Training Request Form**

EMPLOYEE NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

EMPLOYEE EMAIL ADDRESS: \_\_\_\_\_

EMPLOYEE SOCIAL SECURITY NUMBER: \_\_\_\_\_ COST CENTER: \_\_\_\_\_

EMPLOYEE WORK ADDRESS: \_\_\_\_\_

DEPARTMENT/DIVISION/BRANCH: \_\_\_\_\_

STATE EMPLOYEE       CONTRACT EMPLOYEE

LOCATION OF TRAINING: \_\_\_\_\_  
(City and State)

COURSE/CONFERENCE TITLE: \_\_\_\_\_

DATE(S): \_\_\_\_\_ TIME(S): \_\_\_\_\_

VENDOR NAME: \_\_\_\_\_

VENDOR ADDRESS: \_\_\_\_\_

COURSE/CONFERENCE DESCRIPTION: Attach course description/content (i.e., pamphlet, leaflet, page from course catalog etc). A completed registration form is necessary for payment of those costs.

COURSE/CONFERENCE RELEVANCE: (Include in justification: expected benefits to client services or Cabinet process, consequence of not attending, and plan for sharing information with other employees.)

ACCOUNTING INFORMATION	Fund	Agency	Org	PBU	PROJ. NO. (If applicable)
SECOND SOURCE ID					

Availability of Funding: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Budget Designee Signature)

COST ESTIMATE, per employee

Travel \$ \_\_\_\_\_ Lodging \$ \_\_\_\_\_ Meals \$ \_\_\_\_\_ Registration \$ \_\_\_\_\_

Materials \$ \_\_\_\_\_ Other \$ \_\_\_\_\_ (Please list CEU cost under 'Other,' but do not include as part of the total.)

TOTAL: \$ \_\_\_\_\_

This is to certify that I authorize my employing agency, at its discretion, to deduct from my pay any or all sums paid on my behalf if: 1) my application contains any material falsification; 2) I fail to provide evidence of successful completion to the agency within 10 work days of the completion of training; 3) my employment with the agency is voluntarily or involuntarily terminated prior to the training specified above; 4) during such training, I drop the training regardless of cause without prior approval of my Office/Department head. I further authorize my educational or training institution to provide my employing agency with a copy of my grade report from the course listed above, if any.

EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PRINT SUPERVISOR NAME \_\_\_\_\_

SUPERVISOR SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PRINT DEPT/OFFICE APPROVAL NAME \_\_\_\_\_

DEPT/OFFICE APPROVAL SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_