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Innovative Services for Individuals with Developmental & Mental Health Challenges

Training Request

| | | |
|--|--------------------|--|
| Please register the following employee: | | |
| Name: | | Program Name: |
| Employee's Personal Information: (to be used for confirmation, reminder and in the event of cancellation) | | |
| Home Address: | | |
| Home Phone: | | Home E-mail: |
| Complete this section if training is offered through Support Solutions: | | |
| Class: | Date(s): | Time(s): |
| Complete this section for trainings not provided by Support Solutions: | | |
| Training Offered Through: | | |
| Training Cost: | Place of Training: | |
| Instructors Name: | | |
| Date(s) of Training: | | Time(s): |
| Employee Signature: | | Date: |
| Supervisor's Name (Please Print): _____ | | Date: |
| Supervisor's Signature: _____ | | |
| Confirmation: | | |
| <input type="checkbox"/> | Yes | You have been registered into this class. |
| <input type="checkbox"/> | No | Sorry you have not been registered for <u>this</u> class. |

Please **wait** for confirmation from the Training Coordinator.

If you have questions regarding this training please see your Supervisor for more information.