ALLEVIANT
HEALTH CENTERS™
Heal Pain. Restore Hope. Regain Purpose.

TRAINING Request Form

Name of employee: ______________________________ Date of request: ____________________

Name of training: ____

Organization providing training: ____

Location (online vs. travel): ____

Training Date(s): ____ # of CEs provided ___________

Amount of time away from clinical work ____________________________ Cost $ _____________

Supervisor Approval

______ Approved ______ Disapproved

Amount of fees paid by Company $ ___________

Employee PTO vs. Number of paid hours of training "on the clock" ____________________________