



Workshop Request (School)

In order to meet the needs of your school, please provide the following information in a timely fashion. **Please note that the requested workshop will not be confirmed until Autism New Jersey staff has sufficient information to determine if we can meet your training needs.**

1. Name of school: _____

2. Address: _____

3. Phone number: _____

4. Contact person: _____

5. Possible workshop dates (*not set until confirmation): _____

6. Will you have a projector available for the PowerPoint presentation? _____

7. What is the requested topic?

8. Please list a minimum of 3 objectives you would like your staff to learn from this training. In other words, what are your goals for your staff as a result of this?

OFFICE USE ONLY

Snt _____ Rcd _____ Dec _____ FFS? _____ Rpt _____ Prs _____ Pd _____

9. Please describe the estimated number of each staff group that will attend this workshop (special educators, general educators, paraprofessionals, CST, etc.) and their approximate level of knowledge and skills with respect to autism and behavioral programming.

10. Does your school district have an identified lead for behavioral programming?
YES / NO

(a) If yes, does s/he have current BCBA or BCaBA certification status? YES / NO

(b) If BCaBA, who is supervising him/her?

(c) If not BCBA or BCaBA, please describe practical behavior analytic experience.

(d) How much time does that professional typically commit to the identified classroom or student?

11. How will concepts and skills presented in the workshop be followed up on and integrated into your program?

12. Please describe your school (e.g., ages of students, disabilities, functioning levels, staffing ratio, special education, inclusion, vocational).

13. What are typical teaching approaches/methods used in your school?

14. Additional Information:



Please initial to show your agreement with the following statements:

_____ Attendance at an Autism New Jersey workshop does not constitute endorsement or certification of the agency's program, nor does it represent a determination of the receiving agency's competency in the areas of autism or applied behavior analysis. No such claims should be made.

_____ Following confirmation, Autism New Jersey maintains the right to cancel the workshop should information not included in this request be deemed incompatible with Autism New Jersey's mission. Autism New Jersey will communicate this via telephone and in writing.

_____ The agency shall indemnify and otherwise ensure that Autism New Jersey, Inc., its Board of Trustees, and its representatives are held harmless for any damages or injury which may occur during or subsequent to the workshop.

_____ In the event that a presentation must be canceled, the agency will notify Autism New Jersey with a minimum of 24 hours notice.

Thank you for your time in completing this form thoroughly so we can determine if we can fulfill this request. Please return it to Elizabeth Neumann, BCaBA via e-mail, fax, or mail.

E-mail: eneumann@autismnj.org

Fax: 609.588.8858

Mail: 500 Horizon Drive, Suite 530, Robbinsville, NJ 08691