

FUNDING SOURCE:
 Unit Code: _____
 Project Code: _____
 403 Required/Attached:
 Yes ___ No ___

**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
 OUTSIDE TRAINING REQUEST (OTR)**

Complete this form to request authorization to attend outside training. Without a purchase order, the Department will not be liable for registration fees for employees that registered directly with outside trainers/vendors. Incomplete/inaccurate forms will be returned to the appropriate Bureau Analyst.

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| <p>Indicate the Type of Outside Training Request:</p> <p><input type="checkbox"/> Clinical (Trainings identified as one that will enhance clinical skills). – Submit to Workforce Education and Training (WET) Division, 695 S. Vermont Ave. 15th Fl., Los Angeles, CA 90005 ATTN: Outside Training Request or fax to (213) 252-8775</p> <p><input type="checkbox"/> Non-Clinical (Trainings identified as one that will enhance administrative/technical skills). – Submit to Human Resources Bureau (HRB) – Training Division – 550 S. Vermont Ave., Room 700, Los Angeles, CA 90005 or fax (213) 252-1768</p> | <p>NOTE: Outside Training Request must:</p> <ol style="list-style-type: none"> 1) Include approval by the employee’s supervisor/manager, Bureau Budget Analyst, and District Chief/Deputy Director; 2) Completed and submitted consistent with DMH Policy/Procedure No.106.04; 3) Identify funding source; and 4) Submit to the WET Division or HRB Training Division <i>at least six (6) weeks prior to the date of the scheduled training.</i> It is the responsibility of the employee and the respective management to properly complete and submit all forms in a timely manner. <p><u>For OTR status update: please contact the appropriate Training Division</u></p> |
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DATE OF REQUEST: _____ EMPLOYEE NAME: _____
 EMPLOYEE # _____ PAYROLL TITLE: _____
 WORK ADDRESS: _____ PROFESSIONAL LICENSE # _____
 TEL.#: _____ E-MAIL: _____ FAX # _____
 PROGRAM/BUREAU: _____ DIVISION: _____

Note: If you are traveling **outside the County of Los Angeles** for this training, you must submit a **Travel Request via Service Catalog** <http://servicerequest.dmh.co.la.ca.us>. (Policy/Procedure No. 107.1)

TITLE OF TRAINING: _____
 LOCATION OF TRAINING: _____
 DATE(S) OF TRAINING: _____
 TRAINING SPONSOR/VENDOR: _____

Note: Employees are responsible for the cost of Continuing Education (CE), Continuing Education Units (CEU) and Continuing Medical Education (CME).
JUSTIFICATION: Please describe below how the Department will benefit from your attendance at the training. **“See Brochure” or “See flyer” is not acceptable as justification.** The brochure, flyer, or informational bulletin must be attached to this request.

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|---------------------|-------|
| REGISTRATION FEE \$ | _____ |
|---------------------|-------|

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|---|---|---------------|
| Employee Signature | Employee Name (Print) | Date |
| Supervisor Signature | Supervisor Name (Print) | Date Approved |
| Bureau Budget Analyst Signature | Bureau Budget Analyst Name (Print) | Date |
| District Chief or Deputy Director Signature | District Chief or Deputy Director Name(Print) | Date Approved |

THE SECTION BELOW TO BE COMPLETED BY THE WET OR HRB TRAINING DIVISION

Request for funding is: Approved Denied _____
 Signature Date