TRANSGENDER HEALTH PROGRAM
EDUCATION AND CONSULTATION REQUEST

Name of Agency/Organization: ____________________________

Organization Type: ______________________________________

Contact Name(s): ________________________________________

Contact Number: ____________________________ Contact Email: ______________________

Training Details:

Size of Audience: ____________________________ Duration of Training time: ______________

Desired Date(s): ____________________________ Desired Time: __________________________

Desired location of training: ____________________________

Equipment you have available:

<table>
<thead>
<tr>
<th>Projector</th>
<th>Computer</th>
<th>Speakers</th>
<th>Microphones</th>
<th>White Board</th>
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Target Audience (check all that apply):

□ Medical Providers (MD’s, NP’s, PA’s, ND’s, etc.)

□ Nurses (RN’s, LPN’s, CAN’s, etc.)

□ Ancillary Staff (Medical Assistants, Front Desk, Referral Coordinators, etc.)

□ Mental Health Providers (QMHA’s, QMHP’s, LCSW, LPC, MFT, etc.)

□ Other (please describe): ____________________________

Content Request (check all that apply):

□ Introduction to gender diversity

□ Gender dysphoria and mental health

□ Hormone therapy and gender affirming surgery

□ Assessment and planning for surgery

□ Other (please describe): ____________________________

Will you be providing continuing Education credits?  Yes □  No □  Not sure □