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:

Projector ☐ Computer ☐ Speakers ☐ Microphones ☐ White Board ☐

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 ☐