



INDIANA COALITION AGAINST DOMESTIC VIOLENCE, INC.

PROVIDER APPLICATION Form B

DATE SUBMITTED _____

NAME OF AGENCY: _____

FACILITATOR NAME: _____

ADDRESS: _____

TELEPHONE: _____ **EMAIL:** _____

Applying for: (select one)

____ Trainer ____ Supervisor ____ Facilitator ____ Co-Facilitator

NUMBER OF BIP SESSIONS:

Observed: ____ Agency: _____ Location (if applicable): _____

Co-Facilitated: ____ Agency: _____ Location (if applicable): _____

Facilitated: ____ Agency: _____ Location (if applicable): _____

Name of ICADV Certified Supervisor/Trainer: _____

Telephone: _____ Email: _____

I certify that the provider applicant above completed the foregoing number of BIP sessions indicated above under my supervision.

ICADV Certified Supervisor/Trainer Signature

Date Signed

TRAINING AND CONTINUING EDUCATION

*Area of Training hours are classified as follows: (1) Domestic Violence (2) Group Facilitation Skills (3) Cultural Diversity Issues (4) Substance Abuse (5) Mental Health

<u>DATE of TRAINING</u>	<u>NAME of TRAINING/SPONSOR</u>	<u>NUMBER of HOURS</u>	<u>*AREA of TRAINING</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

TOTAL NUMBER OF TRAINING HOURS

<u>Domestic Violence</u>	<u>Group Facilitation</u>	<u>Cultural Diversity</u>	<u>Substance Abuse</u>	<u>Mental Health</u>	<u>TOTAL HOURS</u>
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I CERTIFY THAT THE INFORMATION GIVEN IN PROVIDER FORM B IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

BIP Program Director

Provider Applicant

(Print name)

(Print name)

Date