FUNDING SOURCE:
Unit Code: _____
Project Code: _____
LACDMH 403 Form Required/Attached:
Yes ☐ No ☐

LOS ANGELES COUNTY 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.

Indicate the Type of Outside Training Request:	**NOTE:** Outside Training Request must:
☐ ***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) 622-5875*** ☐ ***Non-Clinical*** (Trainings identified as one that will enhance administrative/technical skills). – Submit to ***Human Resources Bureau (HRB) – Training Division – 420 S. San Pedro St., G-3, Los Angeles, CA 90013 or fax to (213) 622-5875***	1) Include approval by the employee's supervisor/manager, Bureau Budget Analyst, and District Chief/Deputy Director; 2) Completed and submitted consistent with LACDMH Policy/Procedure No. 614.03; 3) Identify funding source; and 4) Submit to the WET Division or HRB Training Division ***at least six (6) weeks prior to the date of the scheduled training***. It is the responsibility of the employee and the respective management to properly complete and submit all forms in a timely manner. **For OTR status update: Please contact the appropriate Training Division**

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://dmhhqportal1/Pages/default.aspx**. (LACDMH Policy/Procedure No. 900.01)

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.

_____

_____

_____

REGISTRATION FEE $ _____

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