LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH CLIENT LEADERSHIP TRAINING

Name:		
LAST NAME		FIRST NAME
Address	s:	
	STREET NUMBER	
	CITY	ZIP CODE
Telepho	one:	
	HOME	CELL OTHER
E-mail:		
Refere	nce (mental health	HOW OFTEN DO YOU CHECK YOUR E-M/ rofessional recommending you for this program)
Name:		
	LAST NAME	FIRST NAME
	nce (mental health	HOW OFTEN DO YOU CHECK YOUR E-M, ofessional recommending you for this program)

E-mail: ______Telephone:______

Eligibility:

Contact Information:

This training is for individuals who have not participated in past Client Leadership trainings. It is designed for clients who are working on their path to recovery, and doing well. You must be willing to commit to the following requirements:

- Work on a project in your community or in LACDMH where you can put to use the skills you learn in this training.
- Attend all four sessions, and actively participate
- Complete homework assignments
- Answer the questions listed on the attached sheet

SUBMIT YOUR APPLICATION TO: e-mail: malquijay@dmh.lacounty.gov or fax: (213) 252-8767







MENTAL HEALTH SERVICES ACT IN ACTION

THIS TRAINING IS SPONSORED BY LACDMH/E&A DIVISION

Please answer the questions listed below. If you need more space, feel free to attach another sheet of paper.

1. What is a volunteer opportunity in your community or in LAC-DMH in which you are willing to be involved?

2. How do you want to be involved with this volunteer opportunity? (e.g., as a member of a team, as an organizer of outreach efforts, as a presenter, etc.)

3. When are you willing to start your volunteer efforts? (Please choose a date within one month of the completion of your training. See dates on next page)

Name:				
PRINT	SIGNATURE			

Date: _____

SUBMIT YOUR APPLICATION IMMEDIATELY TO: e-mail: <u>malquijay@dmh.lacounty.gov</u> or fax: (213) 252-8767