



OK-AIMH

Oklahoma Association for Infant Mental Health

Request for Training

Name of Person Requesting Training: _____

Organization Affiliation: _____

Phone: _____ Email: _____

Description of Training Audience: _____

Type of Training Requested: (Check all that apply) (See attached price sheet for cost details*)

☐ Infant Mental Health ☐ Reflective Practice (Basic) ☐ Adverse Childhood Experiences

☐ Infant Mental Health Endorsement ☐ Childhood Trauma ☐ Reflective Practice (In-Depth)

☐ Attachment ☐ Relationships and Brain Development ☐ Working with Teen Parents

Training Hours Requested: _____ Date of Training: _____

Time of Training: ☐ Morning ☐ Afternoon ☐ Evening ☐ All Day ☐ Weekend

Name of Training Location: _____

Address of Training: _____

To request training at a reduced cost please submit in writing the reason for the need to reduce cost.*

Submit training request form and any additional documentation to:

Bonnie Bellah, BSW, IMH-E (I)
OK-AIMH Endorsement Coordinator

okaimh@gmail.com

P.O. Box 685

Oklahoma City, OK 73101

For office use only:

☐ Training Approved Notes: _____

Trainer: _____ Total Cost of Training: _____