FUNCTIONAL ASSESSMENT SERVICE TEAM (FAST)
COURSE APPLICATION

NAME:	TITLE:
AGENCY/ORGANIZATION:	GOV / NGO *(CIRCLE ONE)*
WORK PHONE:	E-MAIL:

WHICH TRAINING LOCATION/DATES ARE YOU PLANNING TO ATTEND?

MY DIRECT SERVICE SKILL SET INCLUDES:

DISABILITY AREA:	# OF YRS.	DISABILITY AREA:	# OF YRS.
Aging		Medical/Chronic Health Conditions	
Developmental/Intellectual/Cognitive		Deaf/Hard of Hearing	
Vision		Mental Health	
Physical Disabilities		Behavioral Health *(substance abuse issues)*	

Describe your professional experience and related personal experience that qualifies you to be a FAST member *(you may include any information about current licenses that are related to your present position)*.

Describe your emergency response experience.

If you have any disabilities, special dietary needs, allergies or medical conditions which require accommodation during your attendance, please indicate below.

Applicant: I have read the FAQs on the FAST website (http://www.cdss.ca.gov/dis/PG1909.htm)

SIGNATURE

Applicant's Supervisor: I have reviewed the FAST program FAQs and discussed the program with the applicant. I understand and support the applicant's commitments for FAST training and deployment.

PRINTED NAME

SIGNATURE

Some accommodations require notification up to 2 weeks prior to the training to make the necessary arrangements.