**PSYCHIATRIC SECURITY REVIEW BOARD**

**Psychiatric Security Review Board (PSRB) Training**

ENROLLMENT REGISTRATION FORM

**Training will be held virtually via Microsoft Teams**

***PLEASE CHECK ONE DATE:***

[ ]  **January 4, 2024 from 1:00pm-3:30pm**

[ ]  **February 1, 2024 from 9:00am-11:30am**

[ ]  **March 7, 2024 from 1:00p-3:30pm**

[ ]  **April 4, 2024 from 9:00am-11:30am**

[ ]  **May 2, 2024 from 1:00pm-3:30pm**

[ ]  **June 6, 2024 from 9:00am-11:30am**

[ ]  **August 1, 2024 from 9:00am-11:30am**

[ ]  **September 5, 2024 from 1:00p-3:30pm**

[ ]  **October 3, 2024 from 9:00am-11:30am**

[ ]  **November 7, 2024 from 1:00pm-3:30pm**

[ ]  **December 5, 2024 from 9:00am-11:30am**

***Check One:***

|  |  |
| --- | --- |
| ☐ DMHAS State Employee | ☐ DMHAS Funded Agency Employee |
| ☐ State Employee (Non DMHAS) | ☐ Other (please explain) |

Your Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***Last Name First Name***

Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Tel: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**(REQUIRED)**

***Check One:***

[ ]  I am currently providing treatment or supervision to a PSRB acquittee in the community.

[ ]  I anticipate providing treatment or supervision to a PSRB acquittee in the community within the next year.

[ ] This training is not mandatory for me but I am interested in learning about the PSRB.

**It is preferred that this form be typed and emailed to Jeff.Granata@ct.gov**