



MENTAL  
HEALTH  
FIRST AID®

Please complete and submit this form to:  
**ODMHSAS**  
Attn: Kodi Pollard, Sr. MHFA  
Prevention Field Representative  
2000 N. Classen Blvd, Suite 600  
Oklahoma City, OK 73106  
Email: [kapollard@odmhsas.org](mailto:kapollard@odmhsas.org)

## REQUEST FORM

### SECTION I. BUSINESS/AGENCY INFORMATION

Date: \_\_\_\_\_ Business/Agency Name: \_\_\_\_\_ Contact Person: \_\_\_\_\_

**\* PLEASE CHECK ✓ IF ONLY NEED MANUALS \_\_\_\_\_ IF YOU ONLY NEED CEUs \_\_\_\_\_**

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Email: \_\_\_\_\_

**Please  that describes your establishment:**

School/School District  Organization/Business

Behavioral Health Agency

Other: \_\_\_\_\_

### SECTION II. TRAINING REQUEST INFORMATION

**Type of training requested. Please  all that applies:**

YMHFA (Youth Mental Health First Aid) \_\_\_\_\_  
Request date(s)

MHFA (Mental Health First Aid) \_\_\_\_\_  
Request date(s)

One (1) day training (8.00 hours)

Two (2) Half-day trainings (4.00 hours each)

**If you choose the 4.00 hr training, please provide an additional date (a week from your requested date) to schedule the second part of the training: \_\_\_\_\_**

**Date/Time**

**Location**

### SECTION III. RESOURCE INFORMATION

Will manuals need to be provided?  YES  NO How many? \_\_\_\_\_ (cannot exceed 30 manuals)

Address of location where manuals need to be delivered:

**Address**

**City/State**

**Zip Code**

Will Continuing Education Units (CEUs) need to be requested for this training?  YES  NO  
(If YES, please allow up to 30 business days for request to be processed)