



# 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)**