



APPLICATION FOR STEPPING ON LEADER TRAINING

NORTH DAKOTA DEPARTMENT OF HEALTH
INJURY PREVENTION & CONTROL
SFN 60413 (7-2013)

Stepping On - Falls Prevention

Name	Agency		
Address	City	State	ZIP Code
Work Phone	Cell Phone		
Email			
Contact Information for Local Sponsoring Organization:			
Name	Agency Name		
Address	City	State	ZIP Code
Telephone Number	Email		

Note: Individuals from North Dakota are encouraged to attend the Leader Training in pairs, unless your community already has a trained STEPPING ON Leader with whom you will be leading your workshop. This information is available through Mandy Slag, 701.328.4537.

Who will you lead your first workshop with?
What are the dates for your first <i>Stepping On</i> workshop?
Where will your workshop be held?

Leader Application

1. Please explain why you want to be trained as a Leader or Peer Leader for Stepping On.
2. Are you a past participant in a <i>Stepping On</i> workshop? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, how did you hear about <i>Stepping On</i> and the Leader Training?
3. If applying to become a Leader , which of the following best describes your background? <input type="checkbox"/> Health-care professional (<i>please specify:</i> _____) <input type="checkbox"/> Aging network professional (<i>please specify:</i> _____) <input type="checkbox"/> Fitness instructor <input type="checkbox"/> Health educator <input type="checkbox"/> Other (<i>please specify:</i> _____)

4. Please describe any experience you have leading or working with groups of older adults, including the size of the group(s), different income levels, cultures and physical or mental challenges.

5. Please describe any barriers or challenges in your becoming a Leader (e.g., energy, time, transportation, availability, health or other physical limitations).

6. What are the communities in which you would be willing to serve as a *Stepping On* workshop Leader?

The following section must be completed by applicant **Leaders**.

By initialing each item below, you are agreeing to the specific responsibilities involved in becoming a workshop Leader with the North Dakota Department of Health. I agree to:

___ Attend the full three-day training course.

___ Work with my sponsoring organization to begin to complete the *Stepping On* "Implementation Plan"

___ Schedule my first *Stepping On* session within three months of the Leader Training.

___ Conduct at least one *Stepping On* community-based workshop each year.

___ Notify the North Dakota Department of Health of all workshops scheduled.

___ Report all workshops on the required reporting forms.

I understand that the *Stepping On* program is very scripted and that it is critical for the success of the programs that Leaders closely follow the script and not share personal advise.

Signature

Date

Our organization agrees to be the sponsoring organization for this *Stepping On* Leader.

Signature of Sponsoring Organization Representative

Date

SPACE IS LIMITED – REGISTER EARLY

Reimbursement is available for three nights lodging, mileage and meals.
Original receipts are necessary for lodging reimbursements.

Please return this application form to:
Mandy Slag, North Dakota Department of Health
600 East Boulevard Avenue, Dept. 301
Bismarck, ND 58505-0200

Contact information for questions or registration:

E-mail: mslag@nd.gov

Telephone: 701.328.4537 or 800.472.2286 (press 1) Fax: 701.328.1412

Thanks for your interest in becoming a workshop Leader with Stepping On!

