

PLEASE TYPE ALL INFORMATION

SBIRT TRAINING PROVIDER NAME:

INSTRUCTOR QUALIFICATIONS FORM

Instructor Name:

Instructor Address:

Instructor Telephone No.:

Degrees and Certifications (List all degrees and certifications held by the instructor):

SBIRT Experience: (List the instructors relevant experience in implementing SBIRT in a clinical setting):

SBIRT Training Experience (List the instructors relevant experience in training other clinicians to implement SBIRT):

PLEASE DO NOT ATTACH A RESUME