

Training Request

School Name/Organization: Address: Phone:

School District Name(if applicable);

Person or Group Requesting Training:

Date Range of Training Request:

How many do you anticipate attending:

Type of Training:

\_\_\_\_Cortical Visual Impairments \_\_\_\_Calendar/Schedule System

\_\_\_\_Assistive Technology \_\_\_\_Communication

\_\_\_\_Person-Centered Planning \_\_\_\_Behavior

\_\_\_\_Transition \_\_\_\_Collaborative Team

\_\_\_\_Interveners \_\_\_\_Usher Syndrome

\_\_\_\_National Intervener Certification

\_\_\_\_Deafblind Etiologies

\_\_\_\_CHARGE

\_\_\_\_Hearing and Visual System and Educational Consideration/Strategies (DB101)

Or submit a request here:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact:



**U.S. Dept. Education #H326C080039.**

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