Stepping On - **Falls Prevention**

Facilitator Application Form for Facilitator Training

THANK YOU very much for your interest in *Stepping On*! We look forward to getting to know you better and working with you to help you become a *Stepping On* Facilitator. Please provide us with the information below to help us plan for our upcoming *Stepping On* Facilitator Workshop.

NAME: ____

MAILING ADDRESS: ____

CITY, STATE, ZIP:____COUNTY:__________________

HOME PHONE:___________________________CELL PHONE: ______________________________

E-MAIL: ____

GENDER:____Male____Female DATE OF BIRTH:______________(optional)

RACE: ___White/Caucasian___African-American___Asian____Middle Eastern or North African

____Native American____Other

ETHNICITY:____Hispanic or Latino _____Not Hispanic or Latino

CONTACT INFO for LOCAL SPONSORING ORGANIZATION:

Name:__________________________________Agency Name: _________________________________

Address: ____

Phone:______________________________E-mail: ____

What dates are you planning for your first *Stepping On* workshop?_________________________________

Who will you lead your first workshop with?__________Where will it be held? ______________________

1. Which of the following best describes your background?

   ___health care professional *(please specify)*: _________________________________

   ____aging network professional *(please specify):* ______________________________

   ___fitness instructor
2. Please tell us why you want to be trained as a Facilitator for *Stepping On*.

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

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

5. What are the counties or communities in which you would be willing to serve as a *Stepping On* workshop Facilitator?

The following section must be completed by **Facilitators.** By initialing each item below, I am agreeing to the specific responsibilities involved in becoming a workshop Facilitator with North Dakota falls prevention network. I agree to:

____Attend the full 2 and 1/2-days training course.

___Schedule my first *Stepping On* session within three months of the Facilitator Training.

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

____Notify NDSU Extension of all workshops scheduled.

____Use the statewide marketing materials in all promotional materials; participate in the statewide evaluation data process to be explained at training; keep up-to-date with program updates as provided by WIHA and NDSU Extension; provide up-to-date contact information and maintain communication with NDSU Extension *Stepping On* Program Coordinator.

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

SIGNATURE DATE

Stepping On is supported by funding from the U.S. Department of Health & Human Services, Administration for Community Living, Administration of Aging, and granted through the North Dakota Department of Health & Human Services, Aging Services Division.

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

SIGNATURE, SPONSORING ORGANIZATION REPRESENTATIVE DATE

Please return this application form by email to:

jane.strommen@ndsu.edu

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