Philadelphia Seminar II WRAP Facilitation Training Application 2016 - 2017

Training Date: June 26-30, 2017
Location: MHASP, 1211 Chestnut Street, 10th Floor, Phila, PA 19107

Name: _____

Date of Birth: _____

Gender: _____

Address: _____

Telephone: _____

E-mail:_____

Contact information of a supporter in case of an emergency (Name and Phone Number):

_____

Have you taken the Seminar I WRAP (2 Day or 3 day Mental Health Recovery & Developing your Wellness Recovery Action Plan) 15 - 24 hour training?
(C*ircle one*):
YES **NO**

What is a WRAP? (In your own words, describe what a WRAP is)

_____

_____

_____

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Name one (1) of the 5 Key Recovery Concepts associated with WRAP:

_____

Name one (1) of the 7 Parts of WRAP:

_____

Have you developed and been using your Personal WRAP for at least one (1) month? (C*ircle one*):
YES **NO**

Please describe your experience with using a WRAP:

_____

_____

_____

What is your motivation for wanting to become a WRAP Facilitator?

_____

_____

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_____

How do you plan to use what you learn in this training?

_____

_____

_____

Is there anything else that the facilitators should know about you that will help make this a positive learning experience?

_____

_____

_____

What challenges might you have in participating in an interactive five (5) full days of training and how will you overcome them?

_____

_____

_____

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Please note that space is limited. T*his training is county funded by DBHIDS and open to Philadelphia residents only. If you are from another county or state, please contact your local behavioral health department.**

****Attach a copy of your Seminar I WRAP Certificate to this application.***

****Attendance of the 5 day training is not a guarantee of certification***

****If accepted into the course, you are expected to attend all 5 days. No exceptions!***

****You are expected to have a solid knowledge about WRAP and have developed a personal WRAP of your own.***

****18 participant maximum in each course***

This course includes several practicums where you will be expected to demonstrate your knowledge of WRAP. Acceptance into the course is not a guarantee that you will be certified. Visit www.copelandcenter.org and www.mentalhealthrecovery.com to familiarize yourself with posted literature which may enhance your ability to meet requirements of this course. Further, applicants should be prepared to share their personal experiences using WRAP with others in this course in a positive and supported manner.

You will receive an acceptance or denial letter regarding your application.

By signing below, I understand the demands of this training as stated above, answered the above questions honestly and affirm that I use my own Wellness Recovery Action Plan regularly.

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Signature _____
Date _____

APPLICATION DEADLINE: May 26, 2017

Applications can be sent via email to: Crystal.Edwards@phila.gov

Mail: The Department of Behavioral Health and Intellectual disAbility Services (DBHIDS)
1101 Market Street (Aramark Tower), 7th Floor
Philadelphia, PA 19107-2907
Attn: Crystal Edwards

Telephone #: **(215) 685-5464**

Fax: **(215) 685-4986**