Form Approved
OMB No. 0930-0276
Exp. Date:xx-xx-xxxx

NCTSI EVALUATION

TRAINING SUMMARY FORM—COMPLETED BY NCTSN CENTER TRAINER

This training summary form should be completed for each training activity. If a training activity spans several days or weeks, this summary form should be completed after the last session and number of trainees should reflect the maximum number of individuals who attended one or more of the sessions.

1. Training dates (if training was 1 day, indicate the same date in both fields):
____/____/_____ through ____/____/_____

2. Number of training sessions: _____

3. Total duration of training:

   A. Total number of days training was delivered (if training occurred across weeks, please indicate the number of days on which training sessions were held): _____

   B. Total number of hours this training lasted: _____

4. Number of trainees who attended the training: _____

5. Name of training: _____

6. Name of the NCTSN center that provided the training: _____

7. Training delivery method (check one):

- ☐ Presentation
- ☐ Workshop
- ☐ Interactive Workshop
- ☐ Learning Collaborative Session
- ☐ Audio Presentation
- ☐ Webinar
- ☐ In-person Supervision/Consultation
- ☐ Audio/Video Supervision/Consultation

8. Primary agency and organizational role of trainees (Check all that apply):

- ☐ **School**
  - ☐ Teachers
  - ☐ Counselors/Social Workers/Psychologists
  - ☐ Administrators
- ☐ **Juvenile justice agency**
  - ☐ Probation officer
  - ☐ Provider
  - ☐ Administrator

☐ **Child welfare/foster care agency**

- ☐ Social Worker/Case manager
- ☐ Administrator
- ☐ Foster Parent
- ☐ Birth Parent(s)
- ☐ Youth

☐ **Mental health agency**

- ☐ Counselors/Therapists/Clinicians
- ☐ Administrator

☐ **Substance abuse agency**

- ☐ Counselors/Therapists/Clinicians
- ☐ Administrator

☐ **Community-based organization**

- ☐ Advocate
- ☐ Case manager
- ☐ Provider
- ☐ Administrator

☐ **First-responder organization**

- ☐ EMT
- ☐ Provider
- ☐ Administrator

☐ **Health/primary care organization**

- ☐ Nurse
- ☐ Physician
- ☐ Medical Assistant
- ☐ Administrator

☐ **General Public**

- ☐ Family member
- ☐ Caregiver

☐ **Other type of organization or individual (please describe: _____)**

9. Were medical or continuing education units offered for participation in this training? (Check one)

- ☐ Yes
- ☐ No
- ☐ Not applicable

10. Which of the following types of trauma were targeted by this training? (Check all that apply)

- ☐ Sexual abuse
- ☐ Neglect
- ☐ Physical abuse
- ☐ Domestic violence

- ☐ School violence
- ☐ Refugee trauma
- ☐ War-related trauma
- ☐ Medical trauma
- ☐ Secondary trauma/vicarious trauma
- ☐ Other (please describe:_____)
- ☐ Community violence/crime
- ☐ Historical trauma
- ☐ Disaster/terrorism related trauma
- ☐ Grief-related trauma
- ☐ Complex trauma

11. How would you broadly characterize the content area of the training? (Check all that apply)

- ☐ Awareness and education
- ☐ Referrals/triaging
- ☐ Clinical intervention
- ☐ Non-clinical intervention
- ☐ Support service
- ☐ Prevention
- ☐ Psychoeducation
- ☐ Other (please describe:_____)
- ☐ Screening
- ☐ Assessment
- ☐ Crisis intervention
- ☐ Secondary trauma
- ☐ Sensitivity related to interacting with trauma victims and families
- ☐ Cultural competence/cultural adaptation
- ☐ Trauma-informed service delivery

12. If this training focused on particular interventions or assessments, please check all that apply:
(Complete List will be drawn from the ESC/expert panel)

__TF-CBT
__ARC
__PCIT
__CPP
__Trauma Assessment Pathway
__Other: _____
__Other: _____

If other, please describe: _____

13. For topic areas a–m below, please indicate the degree to which each was included in this training. (Check one box per topic area)

	Primary Focus of Training 1	**Key Theme But Not the Primary Focus 2**	**Mentioned But Not Emphasized 3**	**Not Mentioned at All 4**
a. Trauma screening and assessment for children/adolescents entering a system	☐	☐	☐	☐
b. General clinical practice guidelines and approaches for child/adolescent trauma treatment	☐	☐	☐	☐
c. Specific evidence-based or evidence-informed interventions for trauma-exposed children	☐	☐	☐	☐
d. Research, evaluation, and/or quality improvement data regarding assessing and/or	☐	☐	☐	☐

treating child/adolescent trauma				
	Primary Focus of Training 1	**Key Theme But Not the Primary Focus 2**	**Mentioned But Not Emphasized 3**	**Not Mentioned at All 4**
e. Training families, caregivers, and/or consumers about being involved in systems, services and supports	☐	☐	☐	☐
f. Training professionals about family, caregiver, and/or consumer involvement in systems, services and supports	☐	☐	☐	☐
g. Cultural sensitivity and appropriateness of child/adolescent trauma services and supports	☐	☐	☐	☐
h. Coordination across service systems	☐	☐	☐	☐
i. Child trauma-informed disaster and terrorism response	☐	☐	☐	☐
j. Community awareness about trauma and available services and supports	☐	☐	☐	☐
k. Available capacity across systems to provide trauma-informed services	☐	☐	☐	☐
l. Local, State, and Federal guidelines related to trauma services and supports	☐	☐	☐	☐
m. The existence, contents, or importance of a state-level trauma policy/position and/or planning to address child/adolescent trauma	☐	☐	☐	☐

14. Do you or the center plan to assess the outcomes of this training? ☐ Yes ☐ No

If yes, please describe how: _____

15. Training summary form completed by:

☐ Trainer
☐ NCTSN Center Program Staff, other than the Trainer
☐ Evaluation Staff
☐ Other (please specify): _____

PLEASE ATTACH A COPY OF THE SIGN-IN/CONTACT INFO SHEET.