



Behavioral Health Is Essential to Health • Prevention Works • Treatment Is Effective • People Recover

## Assisted Outpatient Treatment Program

May 16-17, 2017 – Las Vegas, NV  
June 1-2, 2017 – Rockville, MD  
June 28-29, 2017 – Detroit, MI

This form can be filled out, saved, and e-mailed back using Adobe Acrobat Reader or Adobe Acrobat Pro. If you are having trouble filling out and saving the form, please download and use the free Acrobat Reader from <https://get.adobe.com/reader/otherversions/>

### REGISTRATION FORM

**SUBMIT COMPLETED FORM BY March 24, 2017 TO [aotregistration@affirmasolutions.com](mailto:aotregistration@affirmasolutions.com)**  
**ALL PAGES MUST BE FILLED OUT**

Please enter 1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> choice:

May 16-17, 2017 – Las Vegas, NV  
June 1-2, 2017 – Rockville, MD  
June 28-29, 2017 – Detroit, MI

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FIRST NAME:	LAST NAME:	
CREDENTIALS:	TITLE:	
ORGANIZATION NAME:		
ADDRESS:		
CITY:	STATE (TWO LETTER CODE):	ZIP CODE:
EMAIL:		
PHONE:	ALTERNATE PHONE (MOBILE):	

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Provide the contact information for up to four additional attending AOT Team members (Please try to include at least one judicial member):

Team Member 1

FIRST NAME:	LAST NAME:	
CREDENTIALS:	TITLE:	
ORGANIZATION NAME:		
ADDRESS:		
CITY:	STATE (TWO LETTER CODE):	ZIP CODE:
EMAIL:		
PHONE:	ALTERNATE PHONE (MOBILE):	

**Team Member 2**

**FIRST NAME:** \_\_\_\_\_ **LAST NAME:** \_\_\_\_\_  
**CREDENTIALS:** \_\_\_\_\_ **TITLE:** \_\_\_\_\_  
**ORGANIZATION NAME:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_  
**CITY:** \_\_\_\_\_ **STATE (TWO LETTER CODE):** \_\_\_\_\_ **ZIP CODE:** \_\_\_\_\_  
**EMAIL:** \_\_\_\_\_  
**PHONE:** \_\_\_\_\_ **ALTERNATE PHONE (MOBILE):** \_\_\_\_\_

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**Team Member 3**

**FIRST NAME:** \_\_\_\_\_ **LAST NAME:** \_\_\_\_\_  
**CREDENTIALS:** \_\_\_\_\_ **TITLE:** \_\_\_\_\_  
**ORGANIZATION NAME:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_  
**CITY:** \_\_\_\_\_ **STATE (TWO LETTER CODE):** \_\_\_\_\_ **ZIP CODE:** \_\_\_\_\_  
**EMAIL:** \_\_\_\_\_  
**PHONE:** \_\_\_\_\_ **ALTERNATE PHONE (MOBILE):** \_\_\_\_\_

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**Team Member 4**

**FIRST NAME:** \_\_\_\_\_ **LAST NAME:** \_\_\_\_\_  
**CREDENTIALS:** \_\_\_\_\_ **TITLE:** \_\_\_\_\_  
**ORGANIZATION NAME:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_  
**CITY:** \_\_\_\_\_ **STATE (TWO LETTER CODE):** \_\_\_\_\_ **ZIP CODE:** \_\_\_\_\_  
**EMAIL:** \_\_\_\_\_  
**PHONE:** \_\_\_\_\_ **ALTERNATE PHONE (MOBILE):** \_\_\_\_\_

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Please submit the completed form to [aotregistration@affirmasolutions.com](mailto:aotregistration@affirmasolutions.com)

For assistance, please contact Courtney Casey at [ccasey@affirmasolutions.com](mailto:ccasey@affirmasolutions.com) or (240) 708-2381

## READINESS ASSESSMENT

Please describe why your team believes an AOT Program is needed in your jurisdiction. Include a brief description of the nature of the problem, including service gaps:

Please describe any current or past efforts to develop and implement an AOT Program in your jurisdiction:

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**Please describe any existing/established use of AOT in your jurisdiction:**

**For each team member, please provide a brief description of his or her role in outpatient treatment efforts or the civil commitment process:**

**Please describe what your team hopes to achieve from this training, and how it will further your current goals:**

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