



CHIEF EXECUTIVE OFFICER  
Jay A. Reeve, Ph.D.

## LIMITED MENTAL HEALTH TRAINING

Chapter 429.075(1) Assisted Care Communities Statute requires the facility administrator and staff of the facility who are in direct contact with mental health residents to complete training of no less than six (6) hours related to their duties. This training will be provided by Apalachee Center, Inc., as approved by the Department of Children and Families. Apalachee Center, Inc. is offering an 8-hour training session that can be used to meet this requirement.

This training session has been scheduled for **Friday, February 15, 2019** from 8:00 am to 5:00 pm (Eastern Time) at Apalachee Center, Inc., 2634-J Capital Circle NE, Tallahassee, Florida 32308. **Registration will commence at 7:45 am, EST.** If you are coming from the Central Time Zone, please adjust your time accordingly.

**Pre-registration is required** as materials will be prepared for only those who are registered. Please complete the attached registration form and fax to: (850) 523-3335 no later than 5:00 p.m. on Tuesday, February 12, 2019. If you would like to mail the registration form, please use the address listed below. If mailing, the form must reach us by 5:00 p.m. on Tuesday, February 12, 2019.

Rae Kelly  
Training and Staff Development Specialist  
Apalachee Center, Inc.  
2634-J Capital Circle NE  
Tallahassee, Florida 32308

A Certificate of Attendance will **only** be issued to those participants who complete the test and attend the **entire** training session. A copy of the provided Certificate must be kept on file at your facility.

If you need additional information or if you need to make arrangements for special accommodations please contact Ms. Rae Kelly at (850) 523-3265 prior to February 13, 2019.

Sincerely,

*Kimberly Owens*

Kimberly Owens  
Training and Staff Development Supervisor  
Apalachee Center, Inc.

**ASSISTED LIVING FACILITY  
LIMITED MENTAL HEALTH TRAINING  
REGISTRATION FORM FOR  
FEBRUARY 15, 2019 CLASS  
FAX #: (850) 523-3335  
Attention: Rae Kelly**

Name of your Facility: \_\_\_\_\_

(Print Legibly)

Facility Mailing Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Facility FAX # **OR** E-Mail Address \_\_\_\_\_

Facility Contact Person and Phone Number \_\_\_\_\_

Please List the Name(s) of Participant(s):

**(Print the name(s) legibly as you would like for it to appear on the Certificate)**

\_\_\_\_\_ **Contact Phone #**

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