



# Behavioral Health Training Partnership

## POST TRAINING ACTION PLAN

Training Title: _____	Date of Training: _____
Name of Participant: _____	
Name of County/Tribe: _____	
Supervisor: _____	
Supervisor Email: _____	

Please list three important concepts, ideas, or skills which you plan to take from the training and implement in your work.

1.
2.
3.

Please identify a plan that you will implement upon return to your agency to implement these concepts.

Please identify resources that will help you implement this plan.

Please identify any barriers to the implementation of this plan.

*Please keep the white copy of this action plan for your records. The yellow copy will be sent to your immediate supervisor to assist in the transfer of learning process within your agency.*