

**CHRONIC DISEASE SELF-MANAGEMENT PROGRAM  
BETTER CHOICES, BETTER HEALTH (FORMERLY LIVING WELL SC)  
Application for Group Leader**

Please read the qualifications listed on flyer and complete this application if you are interested in being a leader.

**Please Print Legibly**

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Phone Number: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Preferred Email Address \_\_\_\_\_

Do you have an ongoing (chronic) health condition?  yes  no

Host Organization (the organization that is sponsoring you to offer Better Choices, Better Health):

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Primary Implementation Site (where you will be offering the workshops):

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

What is your educational background? \_\_\_\_\_

\_\_\_\_\_

Describe your experience working with older adults, people with disabilities, or other relevant experience \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe any experience as a teacher, leader, or trainer \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe any other relevant experience \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you available to lead the six-week workshop at least twice a year?

yes  no

Please describe the site where you intend to conduct the Chronic Disease and Self Management Program (check appropriate box):

	Yes	No
Handicapped accessible entrance		
Handicapped accessible parking		
Handicapped accessible exercise room		
Handicapped accessible bathroom		
Room large enough to enable easy movement for 12 people		
Sturdy chairs that are easy to get in and out of		

Program Location/Facility Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

**Chronic Disease and Self Management Program Group Leader Agreement Form**

As a Chronic Disease and Self Management Program Group Leader, I \_\_\_\_\_ (NAME)

\_\_\_\_\_, of \_\_\_\_\_ (ORGANIZATION)

agree to conduct the program set forth in the Chronic Disease and Self Management Program Manual. I understand that I must be present for all 4 days of the training. Within 3 months of completing the training, I agree to offer a workshop (once a week for 6 weeks) for my organization and at least one more 6-week workshop within 12 months of the training date. I agree to continue to offer the program over time and commit to co-leading 2 workshops per year. I have my organization's commitment to make this a part of its regular programs and/or services.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

**Please submit application and payment by February 13, 2012 to:**

**SC DHEC  
 Arthritis Program Coordinator  
 1751 Calhoun Street  
 Columbia, SC 29201  
 Phone (803) 898-0760**

**Please make checks payable to:  
 Arthritis Foundation  
 (\$50 per person)**