



Successful Living with Chronic Conditions

Chronic Disease Self Management Program (CDSMP)

Experience			
Occupation - present and/or past.			
If currently employed, list position and place of employment.			
List any pertinent volunteer experience you have.			
Health Information			
Do you have a chronic disease?		Yes	No
If yes, what type?			
Does a family member or significant other have a chronic disease?		Relationship	Yes No
Chronic Disease Self Management Program			
Have you participated in a CDSMP program?		Yes	No
What are your reasons for wanting to participate in the CDSMP leader training workshop?			
How do you expect to benefit personally from teaching the CDSMP?			
If applicable, how will your employer benefit from you teaching the CDSMP?			

Polk County Health Department
 1907 Carpenter Avenue
 Des Moines, IA 50314
 PHONE: (515) 286-3767
 FAX: (515) 286-2033
 Email: tkeiter@co.polk.ia.us



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Memorandum of Agreement

To ensure the quality of the Chronic Disease Self-Management Program, the following policies and procedures have been instituted. Please sign below, along with your employer, if applicable, indicating your acknowledgement and acceptance of these requirements.

1. I understand that CDSMP leader trainings and programs must be held in facilities that are physically accessible to the disabled, which have meeting rooms that are safe and comfortable.
2. I understand that the meeting facility or sponsoring organization must have adequate insurance coverage for the Chronic Disease Self-Management Program.
3. I understand that the CDSMP leader training workshop is open only to those who have been pre-screened and approved. All applicants must complete this application form and receive a confirmation letter before being eligible to attend a leader training workshop. Walk-ins will not be allowed into the leader training workshop.
4. I understand that once I have completed the leader training workshop I will be eligible to teach the program in my community. I also understand that only approved **master** trainers can teach others how to be CDSMP leaders. Only persons who have successfully completed the master training workshop conducted by trainers approved by Stanford University are eligible to be master trainers.
5. I understand that guest speakers may not lead any part of the course.
6. I agree to conduct the program in accordance with the program guidelines and agree not to change the program in any way without prior written authorization from the Polk County Health Department.
7. I understand that I will not receive payment from the CDSMP participants for teaching the Chronic Disease Self-Management Program.
8. I understand that once I have lead and completed the six week session, the Polk County Health Department may provide a small honorarium.
9. I agree to complete or schedule my **first** six-week program by the end of **December 31, 2009** and my **second** six-week program by the end of **June 30, 2010**.
10. I understand that my certification as a CDSMP leader will become invalid if I do not teach a minimum of two CDSMP six-week programs each year (**July 1, 2009 through June 30, 2010**).

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11. I agree to teach ALL CDSMP programs with a co-leader.	
12. I agree to coordinate with the Polk County Health Department recruitment of participants and CDSMP workshop sites.	
13. I understand that I am implementing the CDSMP under the Polk County Health Department license, obtained from Stanford University. Neither my employer, if applicable, nor I will be required to pay a CDSMP license fee to Stanford University as long as the CDSMP workshops are coordinated through the Polk County Health Department.	
14. I agree to keep the Polk County Health Department informed of my current contact information.	
15. I agree to contact the Polk County Health Department if at anytime I decide to discontinue implementing the CDSMP.	
16. The Polk County Health Department agrees to provide all teaching materials at no charge.	
17. The Polk County Health Department agrees to keep a database of leaders and conduct conference calls, send emails, and/or U.S. mail notifications when information regarding the CDSMP needs to be communicated.	
18. The Polk County Health Department agrees to all provide technical assistance for the CDSMP.	
Participant Signature: Print Name:	 Date:
Participant's Employer Signature: Print Name:	 Date:
Polk County Health Department Representative Signature: Print Name:	 Date:

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