



BEST INTENTIONS

PEER SERVICES

WOMEN IN TRANSITION RE-ENTRY PROJECT INC.

CHW CERTIFICATION COURSE | INTAKE AND ENROLLMENT

FREE COMMUNITY HEALTH WORKER COURSE | Complete starred fields; optional items help us plan.

COURSE DETAILS

Course name

CHW Certification Course

Course beginning date (MM/DD/YYYY)

10/10/2026

Start time (if known)

7:00 PM Pacific

A CANDIDATE INFORMATION

Legal first name *

Middle initial

Legal last name *

Preferred name (if different)

Date of birth (MM/DD/YYYY) *

Phone number *

Email address *

Street address and apartment or unit *

City *

State *

ZIP code *

Mother's first name *

Mother's maiden name (surname at birth) *

B COMMUNICATION AND DEMOGRAPHICS

Preferred language *

Best way to reach you (select one) *

☐ Call

☐ Text

☐ Email

May we text you? *

☐ Yes

☐ No

May we leave voicemail? *

☐ Yes

☐ No

Race and ethnicity (select all that apply) *

☐ Black / African American

☐ Asian

☐ White

☐ Hispanic / Latino

☐ American Indian / Alaska Native

☐ Native Hawaiian / Pacific Islander

☐ Middle Eastern / North African

☐ Multiracial

☐ Other

☐ Prefer not to answer

If other, please specify

Continue on page 2 for course planning and your signature.



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COURSE PLANNING AND ENROLLMENT ACKNOWLEDGMENT

C COURSE PLANNING

☐ I want to enroll in the free CHW certification course

Preferred schedule (select all that work for you)

☐ Weekdays

☐ Evenings

☐ Weekends

Preferred class format

☐ In person

☐ Virtual

Currently employed or volunteering as a CHW?

☐ Yes

☐ No

Highest education completed (optional)

Approximate CHW experience hours (optional)

Intended qualification pathway (select one, if known)

☐ Certificate

☐ Work experience

☐ Undecided / need guidance

Relevant lived experience you choose to share (optional)

Accessibility or learning support you would like us to know about (optional)

How did you hear about the course? (optional)

D ENROLLMENT ACKNOWLEDGMENT

I request enrollment in the CHW course and confirm that the information I provided is accurate to the best of my knowledge. The course team may contact me using the preferences on page 1.

This form is for training enrollment. It does not request or authorize clinical services.

Candidate signature or typed name *

Date *

RETURN COMPLETED FORM TO **Management@BestIntentionsPeerServices.Org**