

POST – NEW COURSE CERTIFICATION TRAINING NEEDS ASSESSMENT

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This form must be submitted to your POST Regional Consultant the required minimum 60 days in advance of desired course presentation date(s). Please complete ALL portions. This does not constitute for presentation of a course until POST review is final and approval is granted.

A. COURSE INFORMATION

PROPOSED COURSE TITLE The Third Option	DATE SUBMITTED (MM/DD/YY) 10/15/2019
SUBMITTING PRESENTER Miles McPherson	COURSE PRESENTATION DATE(S) – Use commas to separate dates (MM/DD/YY) Nov 22, 2019

Are you affiliated with: A law enforcement agency A Regional Training Center/Institute/Consortium A College
 A 501 (c) (3) or (4) Non-Profit Organization A LLC, S-Corp, etc.

B. CONSULTATION

1. Did you consult with your regional POST Consultant prior to developing this proposed course?..... Y N
 a. IF YES, provide Consultant's Name: Dan Schmitt Date: Oct 29, 2019
 b. IF NO, please give reason: _____

C. DEMONSTRATED NEED

1. Is there a demonstrated **unmet need** expressed by a survey of agencies/associations?..... Y N
 IF YES:
 a. Did you survey the County Chiefs & Sheriff's Association? Y N
 Association Name: _____
 b. Did you survey the training managers association and/or training association group? Y N
 Association Name(s): 1) SD and OC training Managers Association
 2) _____
 c. Did you survey other advisory groups (e.g., Community College Advisory Council)? Y N
 Council Name(s): 1) Anne Calle, Regional Leadership Institute
 2) _____

2. Are there **existing courses** available locally, or that can be imported into the area, to meet the need?..... Y N
 a. Did you survey existing courses for performance and viability? Y N
 b. Result findings: Attendance numbers: _____
 Projected presentation numbers: _____

3. Is the course an **expressed priority** by legislation/POST Commission? If YES, Statute or POST Regulation. NA Y N

4. Is there required **POST standardized curriculum**? Y N
 a. IF YES, did you request a copy of the curriculum from your POST Consultant? Y N

D. DEMONSTRATED CAPABILITIES

1. Did you identify **instructional expertise/capability** to instruct this course? Y N
 a. Does the instructor require specialized training (e.g., AICC, Regulation 1070)? Y N

2. Do you have **adequate and safe curriculum** training facilities to hold this type of course instruction?..... Y N
 a. Will this course be presented at multiple locations? Y N
 b. If applicable, will this course require a written **safety policy**? Y N

3. If applicable, has this proposal been **reviewed and approved** by your agency/college chief executive, director, training administrator and training manager (or equivalent curriculum manager)?..... Y N
 Name(s): 1) _____ Title(s): _____
 2) _____
 3) _____

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D. DEMONSTRATED CAPABILITIES *continued*

4. Have you or your agency's training manager and/or administrator attended the POST-certified *Training Administrator's Course* and/or *Training Managers Course*? Y N
 Date: _____ Location: _____

E. ASSESSMENT

1. **Type of Course**
 Basic In-Service Technical Supervisory Management Executive

2. **Requirement(s) (check all that apply)**
 Legislative mandate Commission regulation Local agency need Regional agencies need

3. **Types of Students**
 Affiliated Non-affiliated New hires Incumbent Peace Officer Dispatcher NPO/Non-Dispatcher


4. **Schedule/Attendance**
 a. Number of presentations per year: 9
 b. Anticipated number of trainees attending per fiscal year: 270
 c. Maximum number of enrollees per class presentation: 30

5. Have you completed a budget for this course? Y N
 a. Are there subventions (i.e., FTEs, Grant, Contract, Tuition)? Y N
 IF YES, what are they: _____
 Estimated Tuition Fee per Student: \$ \$250

F. ADDITIONAL COMMENTS

Please provide written comments to further justify training need and to identify the unmet training need.
 The Third Option Similarity Training class is designed to equip each participant to develop honoring relationships with those who look different by empowering them to discover and respectfully engage with the unique greatness of our similarities.

G. AUTHORIZATION PRESENTER NO: _____

SIGNATURE OF INDIVIDUAL REQUESTING/AUTHORIZING COURSE CERTIFICATION (REQUIRED)  DATE <u>10/29/19</u>	PRINT FULL NAME Miles McPherson <hr/> TITLE Director
CONTACT NUMBER 858-967-4834	EMAIL ADDRESS mac330@sdrock.com
PROPOSED PRESENTER Miles McPherson	

FOR POST USE ONLY RECEIVED VIA: MAIL EMAIL FAX RECEIVED BY: _____

THIS SPACE FOR DATE STAMP