

**STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Computer-Based Training (CBT) Development Request Office of Information Services		
Requester Name:	Date:	
Title:	Phone:	
Program/Location:		
Description of CBT Training Requested:		
Reason Needed:		
Below for Organizational Unit / Program Lead Only		
Organizational Unit / Program Lead:	Date Received:	
Program Area(s) Involved/Affected:		
Number and Nature of Staff Affected:		
Criticality/Urgency:		
Related Impending Application/Procedure/Policy/Other Changes:		
Comments/Recommendations:		
Approval (Signature):	Date:	
Below for Technology Training Group (TTG) Use Only		
TTG Chair/CBT Lead:	Date Received:	
TTG Recommendation:		
CBT Developer:	Estimated Development Time:	Est. Start Date: