INTERNAL TRAINING PROGRAM

Program name	
Training coordinator	
Purpose of training	
Training goals	
Duration of program	
Participant(s) Number / Names	
Internal facilitators	
External facilitators	
Date(s) and time(s)	
Location / Room booking	
Type of delivery	☐ **Training** ☐ **Simulation** ☐ **Workshop** ☐ **Presentation**
Equipment required	
Specialised training needs	

KINGFISHER
GARDEN CENTRE