

EMS Training/Refresher Program Approval Application

Training Institution: _____

Address: _____

Phone No: _____

Program Director: _____ Title: _____

Phone: _____ Fax: _____ Email: _____

Clinical Coordinator: _____ Title: _____

Phone: _____ Fax: _____ Email: _____

Principal Instructor: (use additional paper if necessary)

Training Course: (select one) ☐ EMT ☐ AEMT ☐ EMT-P ☐ MICN ☐ Other: _____

Text (Primary): _____

Workbook: _____

Author: _____ Publication Date: _____

Text (Secondary): _____

Workbook: _____

Author: _____ Publication Date: _____

Submitted by:

Name: _____ Title: _____

Phone: _____ Fax: _____ Email: _____

Date Received: _____ By: _____

Date Reviewed: _____ By: _____ ☐ Approved ☐ Disapproved

Training Program Notified Date: _____