

FULL NAME:	(Please PRINT legibly.)			
ADDRESS:	(Street, City, State, Zip)			
LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER:		PHONE NUMBER:		
COURSE DATE(s): (If more than one day, list each date.)	(Day One)	HOURS: (If more than one day, list hours for each day.)	(Day One)	
	(Day Two)		(Day Two)	
TRAINER(s) NAME(s): (If more than one trainer, list all names.)		TIME: (If more than one day, list times for each day.)	(Day One)	
			(Day Two)	
PROGRAM TITLE: (Please check one)	<input type="checkbox"/> Communication Equipment <input type="checkbox"/> Emergency Preparedness Basics <input type="checkbox"/> HAZMAT/HEICS <input type="checkbox"/> Health Risk Communication <input type="checkbox"/> Hospital Emergency Incident Command System	<input type="checkbox"/> Incident Command System <input type="checkbox"/> Laboratory Systems <input type="checkbox"/> Legal Issues <input type="checkbox"/> Mental Health <input type="checkbox"/> Personal Protective Equipment/Worker Safety <input type="checkbox"/> Population Movement <input type="checkbox"/> Strategic National Stockpile	<input type="checkbox"/> Surveillance and Epidemiology <input type="checkbox"/> Weapons of Mass Destruction <input type="checkbox"/> WMD Advanced (I) <input type="checkbox"/> WMD Advanced (II) <input type="checkbox"/> WMD Advanced (III) <input type="checkbox"/> Other (Please Specify)	
PRIMARY EMPLOYER'S NAME:	(Please provide name and town of employer.)	CEU TYPE REQUESTED:	<input type="checkbox"/> CEU <input type="checkbox"/> CME	<input type="checkbox"/> EMS <input type="checkbox"/> Other
SPONSORING AGENCY:	(Name of hospital, agency, etc.)			
TRAINING LOCATION:	(Organization and Town)			
JOB CATEGORY: (Please check the job description that best matches your PRIMARY position) CHECK ONLY ONE BOX!	<u>Public Health Staff:</u> <input type="checkbox"/> Public Health Administrator/Manager <input type="checkbox"/> Public Health Nurse <input type="checkbox"/> Public Health Professional <input type="checkbox"/> Other Public Health Staff <u>Key Hospital-Based Personnel:</u> <input type="checkbox"/> Emergency Room Physician <input type="checkbox"/> Emergency Room Nurse <input type="checkbox"/> Other Hospital Physician <input type="checkbox"/> Other Hospital Nurse <input type="checkbox"/> Infection Control Practitioner <input type="checkbox"/> Hospital Administrator/Manager <input type="checkbox"/> Maintenance/Security Personnel <input type="checkbox"/> Other Hospital Personnel	<u>Key Community and Community Health Care Personnel:</u> <input type="checkbox"/> School Nurse <input type="checkbox"/> Pharmacist <input type="checkbox"/> Elected Government Official <input type="checkbox"/> Other Key Community/School Personnel <u>Community-Based Primary Care Providers:</u> <input type="checkbox"/> Physician <input type="checkbox"/> Midlevel Practitioner <input type="checkbox"/> Mental and Behavioral Health Professional <input type="checkbox"/> Clinic/Practice Administration <input type="checkbox"/> Other Health Care Personnel	<u>First Responders:</u> <input type="checkbox"/> Emergency Medical Technician, Paramedic, Fire/Rescue <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Other First Responder <u>Other</u> (please specify)	