

**REGIONAL TRAINING CENTER for
EMERGENCY MEDICAL TECHNICIANS INC.**
PO BOX 126 OAKLAND GARDENS, NEW YORK 11364

Robert Pace
Chief Instructor
Coordinator

917-709-8318

Chris Goemans
Deputy Chief
Instructor

Course Application

NAME _____ DATE _____

ADDRESS _____

TELEPHONE () _____ CELL PHONE () _____

SOC.SEC # _____ DATE OF BIRTH _____

OCCUPATION _____ POSITION _____

EMPLOYER _____

ADDRESS _____

TELEPHONE () _____

AMBULANCE / FIRE DEPARTMENT _____

ADDRESS _____

TELEPHONE () _____ POSITION _____

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COURSE DESIRED

_____ EMT-BASIC ORIGINAL

_____ EMT-BASIC REFRESHER

_____ C F R -D ORIGINAL

_____ CFR-D REFRESHER

CURRENT EMT # _____ EXPIRATION DATE _____

STUDENT SIGNATURE _____

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ALL applications for EMS courses require the authorization of the Chief officer of their department.

I certify that the above named individual is a member of this organization and he/she is actively involved with the response to medical emergencies as par of his/hers duties. This individual will be covered by N.Y.S. Worker's Compensation coverage of this organization for the duration of this course.

PRINT NAME OF CHIEF OFFICE

SIGNATURE OF CHIEF OFFICE