

REGISTRATION FORM - CONFIDENTIAL

(Please Print)

Course Location:				Course Dates:			
STUDENT INFORMATION							
Last name:		First:	Middle:			Medical License (circle one)	
						Paramedic / EMT-I / EMT-B / RN / MD years experience:	
Is this your legal name?	If not, what is your legal name?		(Former name):		Birth date:	Age:	Sex:
<input type="checkbox"/> Yes	<input type="checkbox"/> No				/ /		<input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.:		
					()		
P.O. Box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.:		
					()		
Tactical Medic Certification (Course)			Issued By:		State Approved?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Date Completed:	Length of course (hours)?			EMT-T Expiration date?			
Supervisor Name / Phone:							

Are you currently providing tactical Medic Support?

Agency:

CONTACT INFORMATION

PHONE NUMBERS

WORK: ()

CELL: ()

FAX: ()

PAGER: ()

OTHER ()

NAME:

E-MAIL:

IN CASE OF EMERGENCY

Name of local (nearest) friend or relative		Relationship to student:	Home phone no.:	Work phone no.:
			()	()

I understand that I am financially responsible for any and all medical care that is rendered to me in the event of an emergency.

The above information is true to the best of my knowledge. I understand that any intentional misrepresentation or false information will result in being denied access to this course, denied issuance of training certification, or removal from the course and forfeiture of any funds paid.

Student signature

Date