

STATE OF NEVADA  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH  
**EMERGENCY MEDICAL SYSTEMS**

**Instructor Hours Tracking Log**

Instructor Name: \_\_\_\_\_

Certification Number: \_\_\_\_\_

<u>Topic</u>	<u>Course Number</u>	<u>Location</u>	<u>Hours</u>	<u>Date</u>

\_\_\_\_\_  
Program Director/Coordinator (Printed Name)

\_\_\_\_\_  
Program Director/Coordinator (Signature)

**By signing and submitting this form to the Division, I hereby attest that this is a true/accurate record of the information listed.**