STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Department of Public and Behavioral Health
EMS Program
4150 TECHNOLOGY WAY, SUITE 101
CARSON CITY, NEVADA 89706
(775) 687-7590

Emergency Medical Services Training Grant Application

Please complete the following application by typing or printing clearly.

Agency Name (Must be a Rural Agency): ____

Training to be conducted (CPR, BTLS, continuing education, ect)____

Amount of funding requested: $_________________________

Local Government Agency to receive and administer the funds (If different from above):______________________________

Address: ____ ______________________
(Street) (City) (State) (Zip) (Tax I.D. #)

Authorized Local Official:____
(Print Name)

Authorized Local Official: ____ Date: ______________________
(Signature)

Training Program Coordinator: ____
(Day time phone #)

Address: ____
(Street) (City) (State) (Zip)

Email address:____

In addition to this application please submit (on agency letterhead) a brief explanation of the need for this training program and; the following information:

- Scope of Work: Needs to include a description or outline of the educational program to be conducted with a list of goals and objectives. For equipment request, need to include a full detailed description of equipment, how the equipment will be used and the impact Nevada.
- The number of EMS personnel expected to participate in the training (for training only)
- A brief description of the geographic area to be served by the training or equipment.
- A detailed budget that shows the total costs of the training program or equipment.

Return application and required documentation to:
Division of Public and Behavioral Health EMS Program
Attention: Connie McFadden
4150 Technology Way, Suite 101
Carson City NV 89706
Phone: (775) 687-7590 Fax: (775) 687-7595

EMS Office Use Only

Date Received: __________________ Reviewed By: _____________________

Approved: _______ Amount Recommended: ______________

Denied: _______ Reason for denial: ____

EMS Program Director: ______________________________ Date:______________ Approved______ Denied_______

Amount authorized:__________________________ Budget/Category: __________