

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

## Division of Public and Behavioral Health

Helping people. It's who we are and what we do.



## Please complete the following application by typing or printing clearly.

Training to be conducted (CPR, BTLS, continuing education, ect)	Agency Name:						
Authorized Local Official:    (Print Namo)   (City)   (State)   (Zip)   (Tax 1.D. 8)	Training to be conducted (0	CPR, BTLS, continuing e	education, ect)				
Address:   Gisect   (City)   (State)   (Zip)   (Tax LD. #)	Amount of funding request	ted: \$					
Authorized Local Official:	Local Government Agency	to receive and administe	er the funds (If different	from above):			
Authorized Local Official:	Address:	(Street)	(City)	(State)	(Zip)	(Tax I.D. #)	_
Authorized Local Official:				, ,	· · · · ·		
Training Program Coordinator:	Authorized Local Official:	(Print Name)					
Address: (Street) (City) (State) (Zip)  Email address: (Street) (City) (State) (Zip)  Email address: (Street) (City) (State) (Zip)  Email address: (Street) (City) (State) (Zip)  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 trainingonly)  A brief description of the geographic area to be served by the training or equipment.  Return application and required documentation to: Division of Public and Behavioral Health EMS Program Attention: Mike Bologlu 4126 Technology Way, Suite 100 Carson City NV 89706 Phone: (775) 687-7590 Fax: (775) 687-7595  EMS Office Use Only  Date Received: Reviewed By:  Approved: Amount Recommended:  EMS Program Director: Approved Denied	Authorized Local Official: _	(Signature)			Date:		_
Address: (Street) (City) (State) (Zip)  Email address: (Street) (City) (State) (Zip)  Email address: (Street) (City) (State) (Zip)  Email address: (Street) (City) (State) (Zip)  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.  Return application and required documentation to: Division of Public and Behavioral Health EMS Program Attention: Mike Bologlu  4126 Technology Way, Suite 100 Carson City NV 89706 Phone: (775) 687-7590 Fax: (775) 687-7595  EMS Office Use Only  Date Received: Reviewed By:  Approved: Amount Recommended:  EMS Program Director: Approved Denied	Training Dragram Coording	ator.					
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Date Received:			Division of Public and		n to:		
Approved: Amount Recommended:  Denied: Reason for denial:  EMS Program Director: Date: Approved Denied			4126 Technolog Carson Cit	y Way, Suite 100 y NV 89706	EMS		
Denied: Reason for denial:			4126 Technolog Carson Cit Phone: (775) 687-759	y Way, Suite 100 y NV 89706 ) Fax: (775) 687-759	EMS		
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