

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

**REQUEST FOR APPROVAL OF EMS COURSE**

APPLICANT:

	<u>Please Print</u>	
(Name)		(Agency/Organization)
(Mailing address)		
(E-mail Address)		(Phone Number)

<u>Type of Course (Check one)</u>			
<input type="checkbox"/> EMR	<input type="checkbox"/> EMR Refresher	<input type="checkbox"/> EMT	<input type="checkbox"/> EMT Refresher
<input type="checkbox"/> AEMT	<input type="checkbox"/> AEMT Refresher	<input type="checkbox"/> Paramedic	<input type="checkbox"/> Paramedic Refresher
<input type="checkbox"/> EMS Instructor	<input type="checkbox"/> Community Paramedicine	<input type="checkbox"/> C.E.U ( _____ hrs)	<input type="checkbox"/> Immunization

Start Date: \_\_\_\_\_ Date of Completion: \_\_\_\_\_

Curriculum: \_\_\_\_\_ Textbook to be used: \_\_\_\_\_

Location of Course: \_\_\_\_\_  
(Physical address and building i.e. school, library, college, ect.)

Please indicate whether or not this course will be open to the public:  Yes  No

Please indicate whether or not you have access to training forms via the EMS Web page:  Yes  No

**NOTE: This request must be submitted to the regional office at least 20 working days prior to the requested start date. A course outline detailing class dates, times, topics and instructors must be submitted with this request.**

COURSE COORDINATOR: I will be responsible for the instruction and presentation of the above course. I understand that any omission of required information or misrepresentation will result in denial of approval and that failure to provide course completion material in the time allowed may result in denial of student certification. I will adhere to the Nevada Revised Statutes and Administrative Code 450B.

\_\_\_\_\_  
Signature (Sign in **BLUE** ink) Date: \_\_\_\_\_

PHYSICIAN OF RECORD: I have reviewed the course outline and list of instructors for this course and agree to provide medical direction for such. I will be responsible, along with the course coordinator, for the instruction and presentation of this course.

\_\_\_\_\_  
(Name: Please Print) MD Signature (Sign in **BLUE** ink) License Number Date

(EMS Office Use Only)	
Date Rec'd: _____	Recommend: Approval _____ Denial: _____
Reason for Denial: _____	
Course #: _____	Approval letter sent on: _____

Mail Request to:  
**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH  
EMERGENCY MEDICAL SYSTEMS**  
4150 Technology Way, Suite 101  
Carson City, NV 89706  
OR E-MAIL  
[EMSTraining@health.nv.gov](mailto:EMSTraining@health.nv.gov)