

New Jersey Department of Health and Senior Services
Office of Emergency Medical Services

EMT TRAINING FUND
CERTIFICATE OF ELIGIBILITY FOR CONTINUING EDUCATION COURSES

Name of Student: _____

Volunteer EMS Agency: _____

Address: _____ County: _____

City: _____ State: _____ Zip: _____

Course Sponsor: _____ New Jersey State First Aid Council, 20th District

Student ID Number: _____ Course Start Date: _____

The undersigned verifies that:

1. All of the information above is true and accurate.
2. The EMT listed above is a member or a prospective member of a volunteer ambulance, first aid or rescue squad and is eligible for reimbursement of EMT training expenses in accordance with N.J.A.C. 8:40A.
3. All monies paid for training will ONLY be made to the course sponsor.

Verified by:

Name of Principal Officer (Print): _____

Title: _____

Contact/Telephone Number: _____

Signature of Principal Officer: _____ Date: _____

NOTICE: It is a crime for any person knowingly or willfully to provide false information on this application, or make deliberately misleading statements regarding the eligibility of applicants [N.J.S.A. 2C:21-4(s)].