

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH DIVISION
BUREAU OF LICENSURE AND CERTIFICATION
EMERGENCY MEDICAL SERVICES
4150 TECHNOLOGY WAY, SUITE 200
CARSON CITY, NEVADA 89706
(775) 687-7090

Emergency Medical Services Training Grant Application

Please complete the following application by typing or printing clearly.

Agency Name (Must be a Volunteer Agency): _____

Training to be conducted (CPR, BTLs, PEPP, ect) _____

Amount of funding requested: \$ _____ (Maximum \$2,500.00)

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:

- A description or outline of the educational program to be conducted with a list of goals and objectives
- The number of EMS personnel expected to participate in the training
- A brief description of the geographic area to be served by the training
- A detailed budget that shows the total costs of the training program including how the required 25% match will be incorporated.

Return application and required documentation to:
Nevada State EMS
Attention: Bob Heath
1020 Ruby Vista Drive, Suite 103
Elko, NV 89801
Phone: (775) 753-1154 Fax: (775) 753-4112

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: _____