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

EMT Training Fund Certificate of Eligibility for Continuing Education Courses

Student's Name: _____ Volunteer EMS Agency: _____

Address: _____ County: _____

_____ Course Site: _____

I.D. 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 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. The EMT listed above has not completed the minimum 48 CEUs required for EMT recertification.

Verified by: _____ Title: _____
(Principal Officer's Signature)

Principal Officer's Name (PRINTED): _____

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