

**New Jersey Department of Health
Office of Emergency Medical Services
PO Box 360
Trenton, New Jersey 08625-0360**

**Emergency Medical Technician Training Fund
INITIAL EMT EDUCATION REIMBURSEMENT REPORT**

Course Sponsor		Tax ID	
Course Coordinator		Telephone	
Course Number	Course Location		

	Number of EMTTF Eligible Students	X	TOTAL
1st Quarter		\$187.50	
2nd Quarter		\$187.50	
3rd Quarter		\$187.50	
4th Quarter		\$187.50	
TOTAL			

AGREEMENT

I certify that all information provided is accurate and in compliance with the Emergency Medical Training Fund P. L. 1992, c143 as amended and all related rules and regulations. I also agree to comply with all laws, rules and regulations governing the operations of the program.

I understand that if any violation of the law, rules and/or regulations governing the operations of this program are identified, that the institution may lose its accreditation and be ineligible to receive funding.

I agree to submit all documentation requested for reimbursement.

I certify that I have read and understand all the above statements.

COORDINATOR SIGNATURE: _____ **DATE:** _____

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

OEMS APPROVAL: _____ **DATE:** _____