

MASSACHUSETTS STATE 911 DEPARTMENT
Fax: (508) 828-2587 or 2585
9-1-1 VESTA TRAINING CLASS - REQUEST FORM

Section I – PSAP Supervisor

Today's Date: _____

PSAP Supervisor or person requesting class: _____
 (full name - include title)

Agency / Department: _____

full mailing address (include city/town, PO Box and Zip)

Tel. Number: _____ **FAX Number:** _____
 (include area code) work (other number you can be reached)

Chief of your department: _____

EMD is: provided In-house CPR certified What EMDPRS is your PSAP using? _____
 Provided by (Certified EMD Resource): _____

Class location: MAYNARD SPRINGFIELD MIDDLEBOROUGH OTHER

CLASS DATES & TIMES: (2 consecutive days:) _____

Section II – Student Information (please type or print clearly)

Mark **YES** if the student is currently employed at your Agency, **P** for prospective employee, **EMT** if the student is requesting OEMS credit for completing the course.

Provide student name as it should appear on his/her certificate

Student Name	Last Four Digits of SS#	Date of Hire/Appointment	YES	P	EMT
1.)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

This student has previously attended 911 training for (name department) _____

(**Important**) Check here if a student requires access or communication accommodations

PSAP Supervisor Signature: _____

Massachusetts State 911 Department USE ONLY

Class Dates: _____ Class Time: _____

Location: _____ CONFIRMED by: _____