



AMBULANCE FUND EMS TRAINING REIMBURSEMENT REQUEST

Information

REQUESTING AGENCY: _____

Mailing Address: _____

Phone: _____

Email: _____

Fax: _____

Description of training reimbursement requested: **(\$400.00 maximum per person)

- MFR EMT EMTS EMTP
- IC OTHER _____

Dates of Training: From: _____ To: _____

Individuals name _____

Cost of the program tuition only: _____
(Reimbursement does not include course supplies, examination fees, or any other associated costs)

Is individual training a member of your fire department?

- Yes No

If this request for reimbursement is approved, the individual must complete the training and obtain a state license. After licensure is obtained, the requesting agency will supply copies of the training bill along with proof of payment and a copy of the state license within one year of the completion of the class. Specifics of reimbursement are listed in the Ambulance Fund Policy and may change from time to time. Please check current policy.

Fire Chief/Fire Administrator Signature Date Township Supervisor Date

County Approval

County Request No. _____ Date Received: _____ Initials: _____

Was this request approved for reimbursement after obtaining the license?

- Yes No