

THE NAACS TRAINING COURSE REGISTRATION FORM

The information on this form is to be gathered for all participants. Please be sure this is completed in its entirety!!! This is very important for our records.

Current Member of NAACS prior to registration: Yes _____ No _____ Membership status will be verified.

Location / Dates of Course you are Registering for: _____ Amount Paid: _____

Personal Information:

Please circle one: Mr. Mrs. Miss. Ms.

Name: _____ Title: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Flight Program / Company Affiliation: _____

Supervisor: _____

Business Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Mailing Address: Home Business

Daytime Phone:(____) _____ Work Phone:(____) _____

Fax:(____) _____ E-Mail Address:(Optional) _____

Certification / Licensure Information (REQUIRED FOR CECBEMS CREDIT. HOME ADDRESS MUST MATCH INFORMATION ON FILE FOR YOUR LICENSURE / CERTIFICATION)

Are you Certified / Licensed? YES NO If yes, State of Certification / Licensure: _____

Certification / Licensure Type (NREMT, State EMT, EMD, etc.): _____

Certification / Licensure Number: _____ Expiration Date: _____

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Years of Air Medical Communications Experience: _____

What you would like to gain from this course? _____

Please contact NAACS 48 hrs before course if you have not received a training manual. 1-877-396-2227. Please fax / mail completed form to the Course Coordinator of the Course you are registering for.