

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

**EMERGENCY MEDICAL TECHNICIAN TRAINING FUND
FINAL REIMBURSEMENT REPORT**

Initial EMT Program Refresher Program Other: _____

New Jersey Course Approval # _____

Program Sponsor	Program Coordinator	Vendor ID #
Sponsor Address	Program Coordinator Telephone #	
Sponsor City, State Zip Code	Program Coordinator Email Address	
Sponsor Telephone #	Sponsor Contact Person	
Program Director	Program Director Email Address	
Course Location (Address)	Course City, State Zip Code	
Total EMTTF Eligible Students		Total Student Enrollment

Initial EMT Program Reimbursement ONLY:

	Number of EMTTF eligible students successfully completed	X	TOTAL
1st Quarter		\$375.00	
2nd Quarter		\$375.00	
3rd Quarter		\$375.00	
4th Quarter		\$375.00	
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 understand that all documentation for reimbursement must be submitted within the same state fiscal year the course was conducted. I also understand that reimbursement requests submitted outside the state fiscal year may be denied.

I agree to submit all documentation requested for reimbursement.

I understand that all documentation may be audited for compliance and that funds reimbursed may be subject to a request to return monies if not in compliance.

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 (N.J.S.A. 2C:21-4(a)).

DOH EMS APPROVAL: _____ **DATE:** _____

EMTTF Eligible Student			
	Name	EMS ID #	Quarter Successfully Completed
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