EMR RECERTIFICATION REQUEST

PLEASE COMPLETE AND SUBMIT THIS FORM TO TRAINING
WHEN ALL ITEMS ARE COMPLETE
INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED

EMPLOYEE INFORMATION			
Last Name:	**First Name:**		**MI:**
Home Address	**City**	**State**	**Zip**
Last 4 digits of SS#:	**Driver's License #:**	**Date of Birth:**	

CERTIFICATE INFORMATION	
☐ **This is a recertification request**	**Current CAL FIRE Certificate Number:**
☐ **This is a new request (at CZU)**	**Unit/Training Institute: CZU**
Instructor:	**Date:**

ATTACHMENTS
☐ **Copy of Current EMR Card or Certificate**
☐ **Copy of Current CPR Card**
☐ **CE Documentation**
☐ **Skills Competency Verification Form**

SIGNATURES	
Employee Signature:	**Date:**
Training:	**Date:**