



Expiration Date:  
CDC 64.52

### APPLICATION FOR TRAINING

1. NAME OF APPLICANT: (Please type or print: Last, First, Middle)

\_\_\_\_\_

2. COURSE REQUESTED: \_\_\_\_\_

Date: \_\_\_\_\_

Location: \_\_\_\_\_

3. SPONSOR OR EMPLOYER:

Organization: (Please specify)

Address: (Street and/or POB, City, State, Zip Code)

\_\_\_\_\_

\_\_\_\_\_

Office Phone: (Area code and number) \_\_\_\_\_

E-mail: \_\_\_\_\_ Fax: \_\_\_\_\_

4. OCCUPATION: \_\_\_\_\_

5. BRIEF DESCRIPTION OF YOUR PRESENT JOB:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. NUMBER OF YEARS IN CURRENT FIELD OF WORK: \_\_\_\_\_

7. EDUCATION: Attended college? No: \_\_\_\_\_ Yes: \_\_\_\_\_

If yes, specify highest degree or number of years attended \_\_\_\_\_

Major subject(s) of study \_\_\_\_\_

8. INDICATE PREVIOUS TRAINING IN MORTALITY CODING OR RELATED SUBJECTS:

(Complete only for mortality medical coding courses.)

\_\_\_\_\_

\_\_\_\_\_

Section 304 (b) of the PHS Act (42 USC 242b) authorizes the DHHS Secretary to provide technical assistance in matters relating to health statistical activities. The principal purpose of the information requested in this form is to select student for training. All information that would permit identification of an individual or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to other persons or used for any other purpose. Provision of the requested information is voluntary; however, failure to supply all information may delay or prevent action on your application.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of the collection of this information, including suggestions for reducing this burden, to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0217).

SIGNATURE OF APPLICANT: \_\_\_\_\_

SIGNATURE OF SUPERVISOR: \_\_\_\_\_

Please return the completed and signed form as soon as possible to:

[Name and address of course coordinator]

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Disease Control and Prevention  
National Center for Health Statistics