

[Name and address of course coordinator]

Expiration Date:

APPLICATION FOR TRAINING

1.	NAME OF APPLICANT: (Please type or print: Last, First, Middle)
2.	COURSE REQUESTED:
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. 7.	NUMBER OF YEARS IN CURRENT FIELD OF WORK: 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.)
active of a and according Act	tion 304 (b) of the PHS Act (42 USC 242b) authorizes the DHHS Secretary to provide technical assistance in matters relating to health statistical vities. The principal purpose of the information requested in this form is to select students for training. All information which would permit identification by individual, a practice, or an establishment will be held confidential, will be used only by NCHS staff, contractors, and agents only when required with necessary controls, and will not be disclosed or released to other persons without the consent of the individual or the establishment in ordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency (PL-107-347). This information may be disclosed in confidence to instructors. Provision of the requested information is voluntary; however, failure to oly all information may delay or prevent action on your application.
sea not Sen	lic reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, rehing existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may 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. d comments regarding this burden estimate or any other aspect of the collection of this information, including suggestions for reducing this burden, DC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0217).
SI	GNATURE OF APPLICANT:
SI	GNATURE OF SUPERVISOR:
Ple	ease return the completed and signed form as soon as possible to:

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