Attachment C

Form Approved/OMB No. 0920-0217

Expiration Date:

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 students for training. All information which would permit identification of any individual, a practice, or an establishment will be held confidential, will be used only by NCHS staff, contractors, and agents only when required and with necessary controls, and will not be disclosed or released to other persons without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347). This information may be disclosed in confidence to instructors. 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-74, 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