



Expiration Date:

Attachment C

NCHS VITAL STATISTICS TRAINING APPLICATION

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

First Name for Badge _____

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 _____

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). 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]

