Attachment B

Form Approved/OMB No. 0920-0217
Expiration Date:

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).

NCHS MORTALITY MEDICAL TRAINING APPLICATION

(Please complete a separate form for each applicant)

APPLICANT INFORMATION (Please type or print)

1. Name: _____
   (Last) (First) (MI)

2. Organization/Agency: _____

3. Address: _____

   _____

   _____
   (City) (State) (Zip Code)

4. Office Phones: _____ _____
   (Office) (Fax)

5. E-Mail Address: _____

6. Supervisor Name: _____ Phone: _____

7. E-Mail Address: _____

8. Background/Experience (i.e., previous courses, etc.): _____

   _____

   _____

SIGNATURE OF APPLICANT: _____

SIGNATURE OF SUPERVISOR: _____

NCHS MORTALITY MEDICAL TRAINING APPLICATION - CONTINUED

Circle each course you wish to attend:

Course	Date	Location	Registration Deadline
Basic Underlying Cause	To Be Determined (TBD)	Research Triangle Park, NC	TBD
Basic Multiple Cause (1 week)	To Be Determined (TBD)	Research Triangle Park, NC	TBD

******* If your office would be interested in attending one of these courses, please indicate which course and how many attendees would be involved so that this can be considered.

Return completed application via email or to:

Dawn McCammon
NCHS/DVS/MMCB
P.O. Box 12214
3210 East Highway 54
Research Triangle Park, NC 27709
Phone: 919-541-5102
Fax: 919-541-1811
E-mail: dok1@cdc.gov

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