



Attachment C

Form Approved/OMB No. 0920-0217
Expiration Date: 5/31/2016

NCHS VITAL STATISTICS TRAINING APPLICATION

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

_____ First Name for Badge _____

2. COURSE REQUESTED: VITAL STATISTICS RECORDS AND THEIR ADMINISTRATION

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. STATE OR LOCAL PERSONNEL: S: ____ L: ____

8. EDUCATION: Attended college? No: ____ Yes: ____

If yes, specify highest degree or number of year's attended _____

Major subject(s) of study _____

9. ATTENDANCE: Attended this course before? No: ____ Yes: ____ what year? ____

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. This information may be disclosed 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 Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0217).

SIGNATURE OF APPLICANT: _____

SIGNATURE OF SUPERVISOR: _____

Please return completed and signed form via email as soon as possible to:

LaDonna Crayton
Registration Methods Specialist
NCHS-DVS-OD

E-mail: lcrayton@cdc.gov
Telephone: 301-458-4398