



**PERSONNEL/EMS SERVICE TRAINING AGREEMENT
AND EMS TRAINING GRANT REQUEST**

North Dakota Department of Health
Division of Emergency Medical Services & Trauma
SFN 8050/R02-05/R08-07/R09-09



Name of First Responder, EMT, Intermediate, Advanced EMT or Paramedic

, hereinafter called the Provider, has met the requirements of the North Dakota Department of Health EMS Training Grant Distribution Policy. The EMT agrees to serve on the

Name of EMS Entity	Service Number
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, hereinafter called the EMS Entity, for a period of no

less than one year following initial certification as a First Responder by the North Dakota Department of Health or as an Emergency Medical Technician, Intermediate, Advanced EMT or Paramedic by the National Registry of Emergency Medical Technicians. The provider agrees to serve the EMS Entity in the capacity of an EMS care provider and shall be available for call and runs at times which are mutually agreed upon between the provider and the EMS Entity. Failure of the provider to supply the amount of required service for the EMS Entity shall constitute a default of this Agreement and require the provider to repay the EMS Entity all initial training course fees paid by the EMS Entity to or on behalf of the provider.

The EMS Entity requests a grant as provided in the EMS Training Grant Program Distribution Policy from the North Dakota Department of Health EMS Training Grant Fund for the training and certification of the above named provider. The provider on whose behalf the grant is being requested is a volunteer, is not compensated more than \$10,000 per year, and is providing patient care or rescue care.

The attached distribution policy is hereby incorporated as a part of this Agreement.

Dated this _____ day of _____, 20_____.

PROVIDER

EMS ENTITY

Signature _____

Signature _____

Name - PRINT OR TYPE	
Social Security Number	
Street Address / PO Box #	
Home Phone	Work Phone
City, State, Zip Code	
Certification Level (First Responder, EMT, Intermediate, Advanced EMT or Paramedic)	
Initial Certification Date	
Training Course Site	

Name - PRINT OR TYPE	
Title	
Street Address / PO Box #	
Home Phone	Work Phone
City, State, Zip Code	

Please Forward This Request To:



Emergency Medical Services & Trauma
ND Department of Health
600 E Boulevard Ave Dept 301
Bismarck ND 58505-0200

This Section for DEMST Use Only:

Approved for Payment: 712050 6631-12330 01
In the amount of \$_____.

Signature: _____ Date: _____