CTOS

* R E G F O R M *
Form: REGFORM; Rev: 031202

Weapons of Mass Destruction Training Program

Sponsored by US Department of Homeland Security (DHS) Office of Grants & Training
Delivered by National Security Technologies Counter Terrorism Operations Support (CTOS)

Course Name: **Course 1:** PER-241

Class Date: (1st Choice) **(2nd Choice)** **Course 2:**

Location: **Course 3:**

PART I: COURSE REGISTRATION INFORMATION

Your name will appear on your certificate as it appears below. **Please Print Characters In Capital Letters Only Using Black Ink.**

Last Name:

Middle:

First Name:

Agency/ Company Name:

Job Title/ Position:

Are you a Federal employee? ☐ Yes ☐ No **Are you a US citizen?** ☐ Yes ☐ No

DOB (MM-DD-YYYY): **Social Security No.(Last 4 Digits):**

Place of Birth: **City:** **State:**

Work Address:

City: **State:** **ZIP:**

Work Phone #: **Fax #:**

Home Address:

City: **State:** **ZIP:**

Home Phone #: +

County:

Email Address

Type of Department/Agency

(Bubble in the **ONE** item that is most similar to the agency/company you noted above. Completely fill in the bubble): ● Airport Authority (PO)

- ○ Airport Authority (PO)
- ○ Ambulance Service (A)
- ○ Emergency Management Agency (E)
- ○ Emergency Medical/EMS (S)
- ○ Fire Department (F)
- ○ Hospital (H)
- ○ National Guard (U)
- ○ Police Department (D)
- ○ Port Authority (RT)
- ○ Private Industry/Sector (I)
- ○ Public Health (P)
- ○ Public Works (W)
- ○ Ranger Station (N)
- ○ Rescue Squad (R)
- ○ Search and Rescue (C)
- ○ Sheriff's Office (FF)
- ○ State Police (SP)
- ○ Volunteer Fire Department (V)
- ○ Other Government Agency (G)
- ○ Local Level (LL)
- ○ Federal Level (FL)
- ○ State Level (SL)
- ○ University (UN)

Type of Jurisdiction:

(Bubble in the **ONE** item best describing your agency's affiliation*):

- ○ City/Township (C)
- ○ County/Parish (U)
- ○ State (S)
- ○ District of Columbia (D)
- ○ US Territory (T)
- ○ Private Sector (O)

(Indicate additional jurisdiction information, Bubble **ONE** from the list below):

- ○ Region (G)
- ○ Metro (M)
- ○ National (N)
- ○ Port (P)
- ○ Federal (F)
- ○ Airport (I)
- ○ Tribal Territory (R)

**NOTE: Military personnel should bubble "District of Columbia" in the first column and "Federal" in the second column*

What is your primary job duty?

(Please bubble the **ONE** that most closely corresponds with your primary job duties; for example if you work for the Water Department, Bubble *Public Works*):

- ○ Disaster Board Member (I)
- ○ Elected Official (B)
- ○ Emergency Management (E)
- ○ EMS (S)
- ○ Explosive Ordinance Disposal (X)
- ○ Fire Suppression (F)
- ○ HazMat (H)
- ○ Search & Rescue (R)
- ○ Hospital Administrator (Q)
- ○ Hospital Planner (Z)
- ○ Governmental/Administrative (G)
- ○ Lab Technician (T)
- ○ Law Enforcement (L)
- ○ Military (M)
- ○ Nurse (N)
- ○ Airport Operations (A)
- ○ Other Health Care (Non-EMS) (C)
- ○ Physician (D)
- ○ Private Sector (V)
- ○ Public Health (P)
- ○ Public Works (W)
- ○ Safety Officer (Y)
- ○ Campus (U)
- ○ Public Safety Communications (J)

Professional Background

(Bubble the **ONE** item which best describes your background):

- ○ Agency Head (AH)
- ○ Emergency Responder (ER)
- ○ Senior Management (SM)
- ○ Elected Official (EO)
- ○ Line Supervisor (LS)
- ○ Volunteer (VO)

Years of Experience

(Bubble only **ONE** from each column):

In Profession	In Agency
○ 0 - 3 Years	○ 0 - 3 Years
○ 4 - 6 Years	○ 4 - 6 Years
○ 7 - 9 Years	○ 7 - 9 Years
○ 10 - 12 Years	○ 10 - 12 Years
○ 13 - 15 Years	○ 13 - 15 Years
○ 16 or more Years	○ 16 or more Years

Experience as Trainer

(If you've had experience as a trainer, please bubble in below):

- ○ Yes
- ○ No

- ☐ Conduct Training for other Departments/Agencies
- ☐ Conduct Training within Department/Agency

WMD Background

(Bubble in **ALL** items below which best describe your background):

- ☐ No prior training/experience
- ☐ At federal level
- ☐ At local level
- ☐ At state level
- ☐ Awareness training
- ☐ Expert (SME)
- ☐ Extensive training (5+ courses)
- ☐ Involved in development of agency/jurisdiction WMD plan
- ☐ Serve on WMD Task Force
- ☐ Several courses (2-4 courses)
- ☐ Work in specialized HazMat or explosive ordnance disposal unit

Privacy Act Statement

The information requested on this form is protected by the Privacy Act of 1974. The purpose for requesting this information is to enable proper processing of your information for access to the U.S. Department of Energy, Nevada Operations training facilities. Failure to proved the requested information may preclude processing your training request.

Respirator Medical Evaluation Questionnaire/Waiver Form

Sex: (M/F) M **Age:** **Height:** ‘ “ **Weight: (lbs.)** **Boot Size:**

- ☐ Trained to wear a respirator
- ☐ Trained to wear a Self Contained Breathing Respirator (SCBA)

Medical Conditions

(Bubble in ALL items below that you have now or have ever had)

☐ Cardiovascular Disease	☐ Pulmonary Disease	☐ Smoke Tobacco	☐ Persistent Cough
☐ Heart Trouble	☐ Shortness of Breath	☐ History of Fainting or Seizures	☐ High Blood Pressure
☐ Diabetes	☐ Defective Vision	☐ Sensation of Smothering	☐ Heat Exhaustion
☐ Ruptured Ear Drum	☐ Defective Hearing	☐ Contact Lenses or Glasses	☐ Taking Prescriptions
☐ Problems wearing a respirator	☐ Fear of Tight or Enclosed Places	☐ Other Conditions that might interfere with respirator use or limit work ability	

Please explain any item check:

I verify that I have been seen by a physician/company medical professional and bee approved to wear a respirator FOR TRAINING PURPOSES ONLY for participation in the National Security Technologies WMD Training exercises at the Nevada Test Site.
I will take full responsibility in doing so and release National Security Technologies from any responsibility.

Student or Medical Representative/Company

Medical Rep. Signature: X_____ **Date:** _____/_____/_____

License # _____ **Title:** _____ **Phone:** _____

Student Signature: X_____ **Date:** _____/_____/_____

Forward application to your state Emergency Management Coordinator. If you have any questions you may call: 702-295-3224.

Applicant’s Signature: X_____ **Date:** _____/_____/_____

Department Head Signature: X_____ Date: _____/_____/_____

State Coordinator’s Signature: X_____ **Date:** _____/_____/_____

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***** Click Here to Complete Your Registration *****