Print Form

Kentucky Division of Emergency Management

Request for Training

Organization Requesting Course:

Agency Name:_____Area #:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Contact Number: ( ) _____

Email Address: _____

Course Name:_____ **Instructor:** _____

Instructor Type: **KCTCS** ☐ **KyEM** ☐ **Other:** _____ ☐

Date(s) of Course:_____

Class Location:_____

Course to be Taught in a:

Classroom ☐ **Meeting Room** ☐ **Other:** _____ ☐

Anticipated Number of Students:_____ **Maximum Classroom Capacity:**_____

I have reviewed this application and I am in agreement with the information listed.

_____ _____
Local EMA Director's Signature Date

_____ _____
Area Manager's Signature Date

_____ _____
KyEM Program Staff Signature Date

KyEM Request for Training Form
Revised: January 25, 2007

Please submit all requests for training to:
Local Programs & Training Branch
Capital City Complex East
1025 Capital Center Drive, Suite 101
Frankfort, Kentucky 40602
Fax: (502) 607-5710