



9-1-1 Telecommunicator Training

Provider Approval Application

Date Submitted

APPLICANT INFORMATION

Organization Name

Primary Contact Last Name

First Name

M.I.

Email Address

Street Address

Street Address Line 2

City

State

Zip Code

Phone Number

Previously held Provider Certification
Number (when applicable)

Applicant Qualifications: Required

Select all that apply / Attach supporting documents

11 CSR 90-4.070(4) Qualifications

Applicant History

Facilities and Equipment

Academic Qualifications

Financial Qualifications

Estimated number of Annual Graduates/Students

Justification for Provider Approval

11 CSR 90-4.070(5)(B)(C) Policies and procedures

Attendance Policy

Instructor Evaluation Methods

Training Outline Requirements

Course Evaluation Plan

Instructor Qualifications

Applicant Comments

TRAINING COMMITTEE REVIEW PROCESS

Date Received for Review

Training Committee Comments

Committee Actions

Approve 1-Year or 3-Year
Certification

Request more information from
applicant

Deny Provider application

Date Recommendation Submitted

SERVICE BOARD APPROVAL

Assigned Provider Certification
Number

Provider Expiration Date

Date Approval Letter Sent

Completed by (Initial)