U.S. Public Health Service
Commissioned Corps Readiness Force
Student Application

Please initial next to each line on the form below confirming that you have met the CCRF course prerequisites. Fax this page along with your completed course application and a copy (front and back) of your BLS for Healthcare Providers card to the CCRF fax number on the following page.

INITIAL	CCRF REQUIREMENTS
	Own at least 2 complete pairs of the Working Khaki uniform.
	APPLICATION PREREQUISITES
	Supervisor's permission to attend.
	Completed physical exam (including medical review) on file with DCP within past 5 years.
	Certified in AHA BLS for Healthcare Providers and recorded on CCRF Officer Summary Page. **You must fax a copy of your BLS card (front and back) with your application.**
	Current licensure (if applicable) on file with DCP and recorded on CCRF Officer Summary Page.
	Immunization requirements completed and recorded on CCRF Officer Summary Page.
	Current APFT recorded on CCRF Website
	Recorded height and weight on CCRF Officer Summary Page.
	Current login and update of CCRF Officer Summary Page.
	Completion of all Core curriculum sessions on the CCRF Online Training Program.

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12300 Twinbrook Parkway · Suite 360 · Rockville, MD 20857
Fax (301) 443-3119

APPLICATIONS MUST BE TYPEWRITTEN **(YOU MUST FILL IN EACH FIELD)**

Course Title:	Course Date: **Select only ONE course date**
Liaison Officer Training	☐ March 1-5, 2004 ☐ June 28, 2004

PHS Serial Number (SERNO)	S.S.N.	Deployment Role	BLS for Healthcare Provider Expiration Date
			/ /

Name (LAST) (FIRST)	Rank:Select one	Category:Select one
	ENS	MED

Home Address:	City, State, Zip Code:

Home E-Mail:	Home Phone:	Mobile/Pager:

Duty Station Address	City, State, Zip Code:

Work E-Mail:	Work Phone:	Work Fax:

OPDIV/Agency:	Current Job Title:

Mode of Transportation: check applicable		If traveling by air, please specify Airports of **Departure**:	
☐ Automobile	☐ Air Travel	1st Choice	2nd Choice

Have you attended this course in the past?
☐ No ☐ Yes If yes, when?

Please list your previous experience that is directly related to your role as a Liaison?	
Supervisor's Name	Supervisor's Signature Date