

**Regional Healthcare Emergency Response Network**

Marquette County Medical Control Authority

420 W. Magnetic • Marquette, MI 49855

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**Training Tracking Form**

**Training Date** (mm/dd/yyyy): \_\_\_\_\_

**Name of Organization/Agency:**

**Location of Training:**

**Training Participants** (optional):

**Type of Training** (select *only one*):

- |  |  |
|--|--|
| <input type="checkbox"/> Seminar             | <input type="checkbox"/> PEP                     |
| <input type="checkbox"/> Workshop            | <input type="checkbox"/> PALS                    |
| <input type="checkbox"/> Conference          | <input type="checkbox"/> TNCC                    |
| <input type="checkbox"/> HAZMAT Awareness    | <input type="checkbox"/> ATLS                    |
| <input type="checkbox"/> HAZMAT Operations   | <input type="checkbox"/> ACLS                    |
| <input type="checkbox"/> Incident Management | <input type="checkbox"/> First Trauma Care       |
| <input type="checkbox"/> WMD                 | <input type="checkbox"/> Simulation              |
| <input type="checkbox"/> PPE Use             | <input type="checkbox"/> RaPiD-T                 |
| <input type="checkbox"/> CISM Basic          | <input type="checkbox"/> ENPC                    |
| <input type="checkbox"/> CISM Advanced       | <input type="checkbox"/> Other (describe): _____ |

**Competency Based:**

- Yes  
 No

**Number and Type of Personnel Trained** (select *all applicable*):

- \_\_\_\_ Physicians  
 \_\_\_\_ Nurses  
 \_\_\_\_ EMS  
 \_\_\_\_ PA/NP  
 \_\_\_\_ Behavioral Health  
 \_\_\_\_ Other (describe): \_\_\_\_\_

**HRSA Funds Allocated:** \$ \_\_\_\_\_

**Course Objectives:**

**Collaborative Contributions?**  Yes  No

**From?**

**Point of contact: Name:** \_\_\_\_\_

**Phone:** ( ) - ext. \_\_\_\_\_

**Fax:** ( ) - ext. \_\_\_\_\_

**Address:** \_\_\_\_\_

**Cty, St Zip:** \_\_\_\_\_

**Email:** \_\_\_\_\_