

Mississippi State Department of Health

Office of Emergency Planning and Response

Course Roster

Instructor: Please complete a form for each participant in the course. Include as much information as possible. Submit all completed forms to the address shown at the bottom of the page.

OEPR Course Number:	Type of Course:	
Teaching Facility/Agency:		
Lead Instructor:	Start Date:	End Date:
Course Location:	Course County:	

SSN _____ **NREMT #** _____

L Name _____ **F Name** _____ **MI** _____

DOB _____ **Sex** _____ **Race** _____

Addr 1 _____

Addr 2 _____

City _____

State _____ **Zip** _____ **County of Residence** _____

Email _____

Phone 1 _____ **Phone 2** _____

Indicate status:	
<input type="checkbox"/> Pass	
<input type="checkbox"/> Fail	
<input type="checkbox"/> Withdraw	
<input type="checkbox"/> Incomplete	
<input type="checkbox"/> Other	
	_____ Instructor Signature
	_____ Date

BEMS use only

Received:
Entered:

Submit to:

OEPR – Bureau of EMS
 Mississippi State Department of Health
 570 E Woodrow Wilson
 PO Box 1700
 Jackson, MS 39215-1700