Certified Instructor Application

Applicant Information

Name: Date:

Organization: County:

Address: City:

Zip: Office Phone: Alt. Phone:

Email: Fax:

Do you have support of your supervisor/commission to conduct training on behalf of Iowa (HSEMD)?

Yes☐ No☐

Supervisor Name:

Phone: Email:

Do you have support of your county emergency manager to participate in the Iowa HSEMD certified instructor program?

Yes☐ No☐

Name of county emergency manager:

Phone: Email:

Does any or all of your salary come from a match to a federal grant or is reimbursed from a federal grant?

Yes☐ No☐

Will you be requesting payment for your services? Yes☐ No☐

Education

College

Dates Attended: Degree

College

Dates Attended Degree

Teaching Certifications

Certifying Organization:

Certificate: Expiration Date:

Certifying Organization:

Certificate: Expiration Date:

Certifying Organization:

Certificate: Expiration Date:

Certifying Organization:

Certificate: Expiration Date:

Certifying Organization:

Certificate: Expiration Date:

Instructor Experience

Organization:

Address: City: State: Zip:

Title of Course/s

Organization:

Address: City: State: Zip:

Title of Course/s

Organization:

Address: City: State: Zip:

Title of Course/s

Organization:

Address: City: State: Zip:

Title of Course/s

Organization:

Address: City: State: Zip:

Title of Course/s

Courses Interested in Teaching

Title of Course: Course #:

Title of Course: Course #:

Title of Course: Course #:

Title of Course: Course #:

Title of Course: Course #:

I acknowledge and agree to the following:

I wish to be considered by Iowa HSEMD as an instructor for the Iowa HSEMD DPF Certified Instructor Program. If I am chosen to be an instructor for the Iowa HSEMD DPF Certified Instructor Program, I agree to have my name and contact information posted on the Iowa HSEMD training website as an instructor for the courses I am approved to teach.

I understand that while acting as part of the Iowa HSEMD DPF Certified Instructor Program I am considered a volunteer representative of Iowa HSEMD and I agree to conduct all courses in a professional manner and in accordance with the materials provided. I understand that it is at the discretion of Iowa HSEMD to remove from the list of approved instructors anyone who receives poor evaluation for any reason, or is otherwise deemed unfit for instruction.

I further understand that I am not eligible for compensation if course instruction takes place during regular, vacation or overtime hours if my employer receives federal funds for salary/wages.

This agreement will remain in effect for a period of one year from the date of resignation or termination from the Iowa HSEMD DPF Certified Instructor Program.

By signing and returning this form, I agree to the above, and that the information you are provided is accurate and true.

Signature: Date:

Attachments (required): Letter of support from county emergency manager, training certificates and training experience