Return completed and signed form to:
EM Resources Coordinator
FAX: 717.218.2950

REQUEST TO USE SPECIAL TRAINING AIDS

Part 1: DEPARTMENT / ORGANIZATION INFORMATION

Requesting Department/Organization: _____
Chief: _____ Phone: _____
Contact Person: _____ Phone: _____

Part 2: TRAINING INFORMATION

Requested Training Aids: _____ Requested Dates: _____
_____ Requested Dates: _____
_____ Requested Dates: _____
_____ Requested Dates: _____
_____ Requested Dates: _____

IMPORTANT: Cumberland County is NOT liable for any accidents or injuries incurred during training operations. However, ANY personnel/department damaging any part of the training aids will be held responsible for said damages.

Part 3: REQUESTING DEPARTMENT AUTHORIZATION

Date:_____

Requestor Signature: _____ Title: _____

Part 4: REQUEST PROCESSING

Date Received by Emerg. Mgmt. Res. Coor.: _____ Date of Acknowledgment: _____

Request Approved: Yes ☐ No ☐ Reason: _____

Coordination for pickup/delivery: _____

Emerg. Mgmt. Res. Coor Signature: _____ Date: _____

Part 5: PICKUP/RETURN

Receiver Signature:_____ Date:_____

Receiver Printed Name:_____

Date Returned:_____

Print Form Clear Form