



**School of Emergency Services
Advanced & Specialized
COURSE TRAINING AUTHORIZATION FORM**

COURSE INFORMATION

Course Title: _____

Course Start Date: ____/____/____ Course End Date: ____/____/____

ATTENDEE

Full Name (PRINT): _____ Last 4 digits of SSN: _____

Rank/Position: _____

Officer Type: FULL TIME PART TIME CIVILIAN

Law Enforcement Corrections DOC Probation Agency Support
• (may require justification for FDLE Trust Funded courses)

AGENCY INFORMATION

Agency Name (NO INITIALS PLEASE): _____

Training Contact Name: _____ Phone: (____) _____

Training Contact EMAIL: _____

Agency Mailing Address: _____

City: _____, FL Zip: _____

Agency Phone Number: (____) _____

REQUIRED AGENCY AUTHORIZATION

The below agency representative is authorized to register and select the type of training credit to be applied for this course pursuant to Rule 11B-35.006(3) F.A.C.

Course Credit: **Salary Incentive** **Mandatory Retraining**

Agency Authorized Representative **Print Name** _____

Agency Authorized Representative **Signature** _____

or DSC assigned ASID Number: _____

SEND VIA EMAIL
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