CTS Payment Request Form

Test Site Location: _____

Date of Test: _____ - _____ - _____ (MM-DD-YYYY)   **Test Site ID #** _____

Name of CTS Coordinator: _____

Written Only Site ☐   **Number of candidates taking test** _____

Written & Practicals ☐   **Total number of candidates taking practicals** _____

[A] + [B]

[A] **Number of candidates taking EMT-Basic Practicals** _____

[B] **Number of candidates taking FR Practicals** _____

Payment Section:

Name of Payee: _____

FIN _____

Address: _____   **Phone:** (___) ___ - _____

_____

_____

Certification:

I hereby certify that all the information provided on this form is correct and that I am not receiving payment from any other source for coordinating this Consolidated Test Site.

_____ - _____ - _____

_____   _____   _____
CTS Coordinator's Signature   CTS Coordinator's Name Printed   Date of Request (MM-DD-YYYY)

_____
CTS Examiner or OEMS Rep Signature

OEMS Use Only:			
Level of Candidates	**Number Tested**	**Amount**	**Total**
Emergency Medical Technician's		$	$
First Responders		$	$
Test Site Coordinator Fee		$	$
Total Consolidated Test Site Cost			$
Date Processed: ___ / ___ / ___ (MM-DD-YYYY)			
Approved By:			