Hoopa Fire Department
Interagency Training Nomination

Course Number:	Course Name:	PRIORITY ___ OF ___
IQCS Session Number:	Course Location:	Course Date(s):
Course Coordinator Name (First, Last): **Blaine McKinnon Jr.**		Course Coordinator Phone Number: **(530) 739-2262**
Course Coordinator E-Mail: **lmckinnon@hoopa-nsn.gov**	Course Coordinator FAX: **(530) 625-4416**	Date Submitted:
Employee's IQCS ID Number:		
Nominee's Name (First, MI, Last):		
Working Job Title:		Email:
Agency Name:		

Home Unit				Nominee's Mailing Address (If Different):			
Street:				Street:			
City:		State:		City:		State:	
ZIP:		Phone:		ZIP:		Phone:	

List Training Completed and Dates Pertinent To This Course:
List Your Past Qualifications Pertinent To This Course:
Nominee's Signature:
Supervisor's Signature (I certify the nominee meets the prerequisites, or if not met I will put the reasons for attending the course in Remarks.)
Remarks: