

STATE OF NEVADA  
DEPARTMENT OF HUMAN SERVICES  
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH  
**EMERGENCY MEDICAL SERVICES PROGRAM**

**Instructor Hours Tracking Log**

Instructor Name: \_\_\_\_\_

Instructor NV EMS Number: \_\_\_\_\_

<b><u>Topic</u></b>	<b><u>Course Number</u></b>	<b><u>Location</u></b>	<b><u>Hours</u></b>	<b><u>Date</u></b>

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Program Director/Coordinator (Printed Name)

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Program Director/Coordinator (Signature)

By signing and submitting this form to the Division, I hereby attest that this is a true/accurate record of the information listed.