WorkInvestNH-EMT

EMT RETENTION INCENTIVE PAYMENT REQUEST

In order to obtain the **$1,000** EMT RETENTION INCENTIVE PAYMENT the employer must fill out this form and provide the requested information.

Please provide the following information for **each affiliated** EMT that you are seeking the **$1,000** EMT RETENTION INCENTIVE PAYMENT:

First Name	Last Name	Last 4 of SSN
EMS Unit Name	EMT Training Start Date	EMT Training End Date
Date of Hire with Current EMS Unit	Date EMT License Obtained	EMT License #
Vendor Code	Remit Address	

I certify on behalf of the employer listed above, that the employee has been affiliated with an EMS Unit for at least six (6) months in a position requiring the employee to maintain an **EMT License**. ○ Yes ○ No

By submitting this RETENTION INCENTIVE REQUEST form and signing below on behalf of the employer I certify that the person(s) that have completed EMT training and for whom training reimbursement is being sought are currently employed by the employer. Further, the payment will be paid in its entirety to the appropriate employee without any deduction by the employer, if the training was paid for by the employee. Further, this payment will be delivered to the employee in the next available employee compensation payment schedule. Further, I acknowledge I am authorized to submit this application on behalf of the employer/applicant and that all the information provided herein is accurate to the best of my knowledge and ability.

Signature _____ Date _____

Title _____

Please email completed forms to: **WorkInvestNH-EMT@nhes.nh.gov**