

**ADVANCED SCCJA TRAINING REQUEST FORM
JULY 1, 2004 - JUNE 30, 2005**

NAME OF DEPARTMENT _____
 NUMBER OF SWORN PERSONNEL _____ PHONE # _____
 MAILING ADDRESS _____
 AUTHORIZING SIGNATURE (Printed) _____

*****ALL REQUESTS MUST BE SUBMITTED BY MAY 14, 2004*****

**Please complete the following information for each class requested:
 (Names are to be listed in order of preference)**

Class Title: _____
Date: _____ **# of slots requested** _____

Name:	SSN:
Name:	SSN:
Name:	SSN:
Name:	SSN:
Name:	SSN:

Class Title: _____
Date: _____ **# of slots requested** _____

Name:	SSN:
Name:	SSN:
Name:	SSN:
Name:	SSN:
Name:	SSN:

Class Title: _____
Date: _____ **# of slots requested** _____

Name:	SSN:
Name:	SSN:
Name:	SSN:
Name:	SSN:
Name:	SSN:

Class Title: _____
Date: _____ **# of slots requested** _____

Name:	SSN:
Name:	SSN:
Name:	SSN:
Name:	SSN:
Name:	SSN:

Class Title: _____
Date: _____ **# of slots requested** _____

Name:	SSN:
Name:	SSN:
Name:	SSN:
Name:	SSN:
Name:	SSN:

Send to: Judy Ellington, PO Box 1993, Blythewood, SC 29016