

**GEORGIA DEPARTMENT OF CORRECTIONS
 GEORGIA CORRECTIONS ACADEMY
 B.C.O.T. TRAINING REQUEST FORM**

TYPE OR PRINT

PRISON/CENTER:	TELEPHONE NUMBER:
WORK LOCATION ADDRESS:	
TRAINING OFFICER:	DATE OF REQUEST:

THIS REQUEST SHOULD BE COMPLETED AND FORWARDED THROUGH APPLICANT'S TRAINING OFFICER TO THE GEORGIA CORRECTIONS ACADEMY. REQUESTS SHOULD BE SUBMITTED NO LATER THAN TEN (10) DAYS PRIOR TO THE BEGINNING DATE OF THE PROGRAM. CONFIRMATION LETTERS AND INSTRUCTIONS WILL BE SENT DIRECTLY TO THE PERSONNEL DEPARTMENT.

COURSE TITLE:	COURSE DATES:	
NAME:	RACE:	SEX:
MERIT SYSTEM TITLE:	EMPLOYMENT DATE:	
EMPLOYEE IDENTIFICATION NUMBER (MANDATORY FOR STATE EMPLOYEES):	DATE OF BIRTH:	
SOCIAL SECURITY NUMBER (MANDATORY FOR NON-STATE EMPLOYEES):	POST CERTIFICATION NUMBER (IF APPLICABLE):	
Vendor ID # (Mandatory for travel Reimbursement):		

SEND TO: **GEORGIA CORRECTIONS ACADEMY AT TIFT COLLEGE
 BCOT POST UNIT
 300 PATROL ROAD
 FORSYTH, GEORGIA 31029**

TELEPHONE NUMBER: 478-992-2837
FAX NUMBER: 478-992-5930

DATE RECEIVED:
DO YOU REQUIRE ACCESSIBILITY ASSISTANCE? () YES () NO (IF YES, PLEASE COMPLETE BACK OF APPLICATION.)

Retention Schedule: Upon completion, this form must be kept at local facility training offices and/or regional training offices until storage capacity is exceeded. This form must then be boxed, labeled by location and year, and forwarded to the Academy Director's office for storage in Bay D, SOSTC Fleet Warehouse which is climate controlled. After retention for at least seven (7) years, only the Academy Director may direct that this form be destroyed.

ACCESSIBILITY ASSISTANCE

Please provide the following information so that appropriate accommodations can be made available to you at the Training Program. Please remember that if a specific accommodation is not requested in advance, it might not be provided on site. Check all categories that apply.

IF YOU ARE HEARING IMPAIRED, IN WHAT FORM DO YOU PREFER TO RECEIVE COMMUNICATION? (Choose one by placing an "X" in the block.)	
<input type="checkbox"/> ASL Interpreting	<input type="checkbox"/> PSE Transliteration
<input type="checkbox"/> Oral Interpreting	<input type="checkbox"/> Tactile Interpreting
IF YOU WOULD LIKE TO USE AN ASSISTIVE LISTENING DEVICE, WHICH TYPE OF CONNECTOR WOULD YOU PREFER WITH YOUR RECEIVER? (Choose one by placing an "X" in the block.)	
<input type="checkbox"/> Headphones	<input type="checkbox"/> Earphone
<input type="checkbox"/> Telecoil Neck loop	<input type="checkbox"/> Silhouette Pick Up Coil
IF YOU HAVE VISUAL OR COGNITIVE DISABILITIES, DO YOU NEED ANY OF THE FOLLOWING? (Choose one by placing an "X" in the block.)	
<input type="checkbox"/>	Audiotape Program Booklet
<input type="checkbox"/>	Large Print Program Booklet
<input type="checkbox"/>	Braille Program Booklet
<input type="checkbox"/>	I will be bringing a personal assistant (e.g. attendant, facilitator, interpreter, etc.)
NOTE: PLEASE LIST THE NAME OF YOUR PERSONAL ASSISTANT SO THAT A NAME BADGE CAN BE MADE FOR HIM/HER. THE REGISTRATION FEE WILL BE WAIVED FOR THIS PERSON.	
Name of Attendant:	
I HAVE THE FOLLOWING ACCOMMODATION NEED THAT WAS NOT LISTED ABOVE:	

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