

New Hire/ Termination Packet



Notice of Employment Form

Notice of Employment must be sent to the ESCB within 30 days of hire or termination.

Non-Disclosure of Confidential 9-1-1 Information Form

Employee must sign this form pursuant to MRSA 25 § 2929
65 - 625 CMR Chapter 1: Standards for Establishing a Statewide Enhanced 911 System

Training Request Form

All required training must be completed within 12 months of hire date, with the exception of NG911, which must be done within 90 days of hire. If several people are taking classes on the same dates, then multiple courses can be checked on a single form.

NG911 Logon Credentials (PSAPs Only)

Supervisors requesting NG911 logon credentials for their employee(s) may use this form or submit a request by email to 911Training.PUC@Maine.Gov . **A middle initial is required for NG911** (If there is no middle name/initial then indicate so by writing N/A in that field). Please list any other agencies an employee works for to ensure calls go to the proper PSAP (Agents will be given multiple logons if they work for more than one agency).

FORMS CAN BE FAXED TO 207-512-5950 OR EMAILED TO
911TRAINING.PUC@MAINE.GOV



STATE OF MAINE
PUBLIC UTILITIES COMMISSION

Mark A. Vannoy
CHAIRMAN

R. Bruce Williamson
Randall D. Davis
COMMISSIONERS

Harry Lanphear
ADMINISTRATIVE DIRECTOR

Public Safety Dispatcher

NOTICE OF EMPLOYMENT / TERMINATION (rev. 1/18)

Forward to the ESCB **within 30 days** of employment or termination.

Please fill out either the EMPLOYMENT or the TERMINATION information, as applicable.

Name (Applicant) _____ Maiden/previous Name(s): _____
(Last) (First) (Middle)

Department: _____ Title: _____

Date of Birth: _____ Sex: _____ SS #: _____
(mm/dd/yyyy) (required by statute)

Official Agency E-mail Address for this Employee: _____ (example: JDoe@mainepd.org)

EMPLOYMENT DATE: ____/____/____ **or** **TERMINATION DATE:** ____/____/____

EMPLOYMENT / TERMINATION LEVEL:

☐

Full Time Dispatcher

☐

Part Time Dispatcher**

Has this employee had basic training for full-time public safety dispatching OUT OF STATE? Yes ____ No ____

If the agency is requesting a waiver of the basic school for this individual, please forward the **Waiver Application Packet** to the Emergency Services Communication Bureau (ESCB)

Has this employee had training in Emergency Medical Dispatch (EMD)? Yes ____ No ____

If Yes, what program? _____ Contact Maine EMS Office for license application process.

**Is applicant otherwise employed w/your agency ? if so, what position ? _____
(i.e. also full-time law enforcement, part-time corrections, other)

TERMINATION: (If termination due to Conviction or Professional Misconduct, please note in comments)

Type of Termination (Please check) Resigned ____ Discharged ____ Retired ____ Deceased ____ Other ____

Comments: _____

**This form MUST be signed by the DEPARTMENT HEAD and submitted to the
ESCB, 18 SHS, Augusta, ME 04333 or faxed to 207-512-5950**

Name (please print): _____ Title: _____

Signature: _____ (phone) _____ Date: _____

Phone: 207-877-8068 or 207-287-1598 or Fax: 207-512-5950 (training office)



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NONDISCLOSURE OF CONFIDENTIAL 9-1-1 INFORMATION (rev.09/16)

I, _____ understand that all information
(print name)
contained in any database, report, audio recording or other record of the Emergency Services Communication Bureau (hereafter referred to as the Bureau) or a Public Safety Answering Point (hereafter referred to as PSAP) is considered "confidential information" to include:

- A. The names, addresses and telephone numbers of persons listed in E-9-1-1 databases;
- B. Names, addresses and telephone numbers that are omitted from a telephone utility directory list at the request of a customer;
- C. Personally identifying information of a caller to a public safety answering point;
- D. Personally identifying information of and any medical information about a person receiving emergency services through the E-9-1-1 system; or
- E. Personally identifying information of any 3rd party, including, but not limited to, a minor, given during a telephone call to a public safety answering point.

I further understand that confidential information may not be utilized for commercial purposes and may not be disclosed in any manner except as follows, and in accordance with agency policy:

- A. to public or private safety agencies for processing emergency calls and providing emergency services;
- B. to a criminal justice agency, as defined in Title 16, section 803, subsection 4, for the purposes of the administration of criminal justice, as defined in Title 16, section 803, subsection 2, and the administration of juvenile justice, as defined in Title 15, section 3308-A, subsection 1, paragraph A, related to an E-9-1-1 call; and
- C. to designees of the Bureau Director for the purpose of system maintenance and quality control.

I further understand that knowingly disclosing confidential information or disclosing audio recordings of emergency calls to the E9-1-1 system in violation MRSA Title 25 § 2929, is a Class E crime and may also result in disqualification for public safety answering point employment as found in Bureau personnel security clearance and data security standards for PSAPs. (65-625 CMR Chapter 1)

(signature of employee) (employing agency) (date)

REFERENCE: MRSA 25 § 2929
65 - 625 CMR Chapter 1: Standards for Establishing a Statewide Enhanced 911 System



Emergency Services Communication Bureau – SHS 18 – Augusta, ME 04330

APPLICATION FOR IN-SERVICE TRAINING (REV. 9/16)

Fax Completed Form to 207-512-5950

AGENCY INFO:

SPECIAL ACCOMODATIONS?

- ☐ ETC* Date: _____
- ☐ EMD & PRO-QA Date: _____
- ☐ EMD Date: _____
- ☐ EFD Date: _____
- ☐ PRO-QA Only Date: _____
- ☐ NG 9-1-1* Date: _____
- ☐ QA Review Date: _____
- ☐ ED-Q Date: _____
- ☐ AQUA Date: _____
- ☐ Other: _____

Agency Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Phone: _____ Fax: _____

APPLICANT INFO:

First Name	MI	Last Name	Email Address	Phone Number	Initials	Lodging (Y/N)	Meals (B/L/D)
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

If agency is requesting applicant(s) attend a supervisor must complete the following:

Signature of Supervisor and initials of applicant hereby release the sponsoring agency and any other department/agency officially connected with the training program from any liability in the case of illness or accident.

Supervisor Signature: _____ Title: _____ Printed Name: _____ Date: _____



Today's Date:

PSAP Name:

Requestor Name:

Requestor Title:

Please check one:

User:

First Name

MI

Last Name

User Role- please check one:

ESCB Use:

Approved ()

Denied: ()

Name:

Title: