



Training Activity Application

Trg-1

PROVIDER NAME: _____ DATE: _____

ADDRESS: _____ PHONE: _____

CITY, STATE, ZIP: _____

WEBSITE: _____ E-MAIL: _____

CONTACT PERSON: _____ PHONE: _____

TITLE OF CONTACT PERSON: _____

SPONSOR OWNERS/DIRECTORS:

Name _____

Address _____

City _____

State _____

Name _____

Address _____

City _____

State _____

TITLE OF TRAINING ACTIVITY: _____

FORMAT OF PROGRAM DELIVERY: _____ LIVE CLASSROOM _____ DISTANCE DELIVERY

If distance delivery, what medium is used: _____

LENGTH OF TRAINING ACTIVITY: (increments of 1 hour; minimum one 60-minute hour) _____

MAIN GOAL OR OBJECTIVE OF TRAINING ACTIVITY: _____

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ATTENDANCE MONITORING POLICY: Provide a statement explaining how you intend to verify student identity and monitor 100% attendance: _____

METHOD OF RECORD MAINTENANCE: Provide a statement explaining your procedure for maintaining all training records for a minimum of four years. _____

Has the provider ever received a disciplinary sanction by any professional licensing or regulating entity of any jurisdiction? _____ YES _____ NO.

If yes, please explain: _____

MULTIPLE INSTRUCTORS SHOULD USE THE Trg-3 FORM FOR ADDITIONAL INFORMATION.

INSTRUCTOR NAME: _____

TELEPHONE # _____ EMAIL ADDRESS _____

List instructor qualifications and experience: _____

Has the instructor ever received a disciplinary sanction by any professional licensing or regulating entity of any jurisdiction? _____ YES _____ NO.

If yes, please explain: _____

THE AMERICANS WITH DISABILITIES ACT (ADA): Any private entity that offers training or examinations related to licensing for professional or trade purposes must offer such courses or examinations in a place and manner accessible to all persons, or offer alternative but equal arrangements. This may include the provision of auxiliary aids and services for persons with disabilities. For more information please contact your Equal Employment Opportunity Commission.

I hereby certify that all information supplied, herein, is true and accurate and that this program will be as it is described and conducted in compliance with the Nebraska Real Estate License Act and the Americans with Disabilities Act (ADA).

CONTACT PERSON SIGNATURE: _____ DATE: _____

PRINT NAME OF CONTACT PERSON: _____

Sponsoring Broker Certification

I hereby certify that I have reviewed the content of this training program and have deemed it to be appropriate training for those real estate licensees affiliated with my broker license and for whom I am professionally responsible. By signing this document I recognize that satisfactory completion of this program may serve to meet the training requirements of the Nebraska Real Estate Commission as stated in NEB. REV. STAT. §81-885.51.

SIGNATURE OF DESIGNATED BROKER: _____ DATE: _____

PRINT NAME OF DESIGNATED BROKER: _____

NAME OF REAL ESTATE FIRM: _____

PHONE NUMBER: _____ E-MAIL: _____