COMMONWEALTH OF MASSACHUSETTS
LEOSA TRAINING COURSE
VERIFICATION FORM

PLEASE PRINT LEGIBLY

LAST NAME	*FIRST NAME*	*MI*	*DATE OF BIRTH*

Instructor's Information	**LEOSA Course Information**
Name _____	Course Name _____
LEOSA Certification Number _____	Course Certification Number _____
Signature _____	Course Location _____
Internal use only - Roster ID _____	Date Completed _____

I _____ certify that individuals named on this form have successfully completed a Law Enforcement Officers Safety Act Training and Qualification Course in accordance with 515 CMR 6.05.

Submit this form to: Massachusetts State Police
Firearms Licensing
470 Worcester Road
Framingham, MA 01702
Firearms.licensing@massmail.state.ma.us

FORM S.P. 402