NEW YORK STATE
Division of Criminal Justice Services
Office of Public Safety
Security Guard Program

SECURITY GUARD TRAINING QUESTIONNAIRE

In an effort to assess the quality of security guard training being provided by NYS approved security guard training schools, the Division of Criminal Justice Services is requesting the completion of this questionnaire.

Name:_____ Date:_____

Signature:_____ Date of Birth: _____

Address:_____ Telephone Number:_____

_____

Are you an employed security guard? Yes ☐ No ☐ Never ☐ No longer employed ☐

Did you complete the Eight-Hour Pre-Assignment Training Course for Security Guards? Yes ☐ No ☐
If yes, continue

Date(s) of training:_____Time of Training: _____a.m. to _____p.m. **OR** _____p.m. to _____p.m.

Name of School: _____

Address of training: _____

Names of instructor(s): _____

How many hours of training did you receive? _____hours

How was the training conducted? (Check all that apply) All Lecture ☐ Some Lecture ☐ All Video ☐ Some Video ☐

Were handouts provided? Yes ☐ No ☐

Were you required to take notes? Yes ☐ No ☐

Did you take a final written examination? Yes ☐ No. ☐

Did you receive a certificate of completion? Yes ☐ No ☐

Did you complete the Sixteen Hour On-The-Job Training Course for Security Guards? Yes ☐ No ☐
If yes, continue

Training began on: Month_____Day_____Year_____ **and finished on**: Month_____Day_____Year_____

Time of training: _____a.m. to _____p.m. **OR** _____p.m. to _____p.m.

Name of School: _____

Address of training: _____

Names of instructor(s):_____

How many hours of training did you receive: _____hours

How was the training Conducted? (Check all that apply) All lecture ☐ Some Lecture ☐ All Video ☐ Some Video ☐

Did you receive handouts? Yes ☐ No ☐

Were you required to take notes? Yes. ☐ No ☐

Did you take a final written examination? Yes ☐ No ☐

Did you receive a certificate of completion? Yes ☐ No ☐

Did you complete the Eight Hour Annual In-Service Training Course for Security Guards? Yes ☐ No ☐
If yes, continue

Date(s) of training:_____Time of Training: _____a.m. to _____p.m. **OR** _____p.m. to _____p.m.

Name of School: _____

Address of training: _____

Names of instructor(s): _____

How many hours of training did you receive? _____hours

Did you receive handouts? Yes ☐ No ☐

How was the training conducted? (Check all that apply) All Lecture ☐ Some Lecture ☐ All Video ☐ Some Video ☐

Were you required to take notes? Yes ☐ No ☐

Did you take a final written examination? Yes ☐ No ☐

Please use the space below to provide any additional information on the security guard training you completed.

_____

_____

_____

_____

_____

_____

Thank you for completing this questionnaire. If you have any questions, please contact the Office of Public Safety, Security Guard Program at (518) 457-4135.

Forward the completed questionnaire either by mail to:

NYS Division of Criminal Justice Services
Office of Public Safety
Security Guard Program
80 South Swan Street Albany, NY
12210

By fax: (518) 485-7639
Or by e-mail to:
Mary.OConnell@dcjs.ny.gov