

COURSE NUMBER: _____

- over -

COURSE MEDICAL DIRECTOR: _____

COURSE DIRECTOR: _____
(Last) (First) (M.I.)

E-mail: _____

1. Certified/Licensed as an: EMT, EMT-Intermediate, AEMT, Paramedic, M.D./D.O. (please circle)
Certificate/License Number: _____ Expiration Date: __/__/__
2. Certified CPR Instructor with: [] AHA [] Red Cross Expiration Date: __/__/__
3. Certified ACLS Provider. Expiration Date: __/__/__ Instructor: Expiration Date: __/__/__
4. Certified PHTLS or BTLS Provider. Expiration Date: __/__/__ Instructor: Expiration Date: __/__/__
5. Certified PEDS/ALS Provider. Expiration Date: __/__/__ Instructor: Expiration Date: __/__/__
6. Instructor Development Course. DPSST, FSAB I & II, NFPA 1, Other: _____ Date of Course: __/__/__
7. Have at least three years experience in prehospital emergency medical care at or above the level of the course to be taught.

I certify that I am in good standing with my certifying/licensing agency(ies) and that I am not currently on probation for any reason.

I am aware of all Oregon Administrative Rules regarding requirements in this application and have answered all questions completely, without reservation of any kind, and I declare under penalty of perjury that my answers and all my qualifications herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial of the above listed EMT course. I further agree that, if I am a certified EMT, such act shall constitute cause for the suspension or revocation of my EMT certificate to practice as an emergency medical technician in the State of Oregon.

_____/____/____
(Signature of Course Director) (Date)

COURSE INSTRUCTOR (If different than Course Director): _____
(Last) (First) (M.I.)

E-mail: _____

1. Certified/Licensed as an: EMT, EMT-Intermediate, AEMT, Paramedic, M.D./D.O. (please circle)
Certificate/License Number: _____ Expiration Date: __/__/__
2. Certified CPR Instructor with: [] AHA [] Red Cross Expiration Date: __/__/__
3. Certified ACLS Provider. Expiration Date: __/__/__ Instructor: Expiration Date: __/__/__
4. Certified PHTLS or BTLS Provider. Expiration Date: __/__/__ Instructor: Expiration Date: __/__/__
5. Certified PEDS/ALS Provider. Expiration Date: __/__/__ Instructor: Expiration Date: __/__/__
6. Instructor Development Course. DPSST, FSAB I & II, NFPA 1, Other: _____ Date of Course: __/__/__
7. Have at least three years experience in prehospital emergency medical care at or above the level of the course to be taught.

I certify that I am in good standing with my certifying/licensing agency(ies) and that I am not currently on probation for any reason.

I am aware of all Oregon Administrative Rules regarding requirements in this application and have answered all questions completely, without reservation of any kind, and I declare under penalty of perjury that my answers and all my qualifications herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial of the above listed EMT course. I further agree that, if I am a certified EMT, such act shall constitute cause for the suspension or revocation of my EMT certificate to practice as an emergency medical technician in the State of Oregon.

_____/____/____

OREGON HEALTH AUTHORITY
EMS & Trauma Systems
PO Box 14450
Portland OR 97293-0450
971-673-0526 Office; 971-673-0555 fax

REQUEST PRACTICAL EXAMINATIONS

[] EMT [] AEMT

EMS TRAINING INSTITUTION: _____

COURSE DIRECTOR: _____ Course Ending Date: ____/____/____

PRACTICAL EXAM INFORMATION:

Date: ____/____/____ Student Check-in: ____ am/pm CO Arrival Time: ____ am/pm

Location of exam: _____

Address: _____

Building/Room: _____

Contact Person: _____ Affiliation: _____

Daytime phone: _____ E-mail: _____