



YEMSA
Yolo County Emergency Medical Services Agency
137 N Cottonwood St
Woodland, CA 95695 – (530) 666-8645

**EMERGENCY MEDICAL RESPONDER
(EMR) TRAINING PROGRAM**

APPLICATION PACKET FOR COURSE APPROVAL



Yolo County Emergency Medical Services Agency

Training Programs

Revised Date: July 28, 2021

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EMERGENCY MEDICAL RESPONDER (EMR) PROGRAM ATTACHMENT CHECKLIST

MATERIALS TO BE SUBMITTED WITH APPLICATION:	ENCLOSED
EMR Training Program Application Form	<input type="checkbox"/>
Program Director Information Form and Supporting Documents	<input type="checkbox"/>
Principal Instructor Information Form(s) and Supporting Documents for each Principal Instructor	<input type="checkbox"/>
Teaching Assistant Information Form(s) and Supporting Documents for each Teaching Assistant	<input type="checkbox"/>
Description of Program Facilities, Equipment, Exam Security, and Student Record Keeping	<input type="checkbox"/>
Course Schedule (include proposed dates)	
Lesson Plans and Objectives	<input type="checkbox"/>
Samples of Written and Skills Exams ¹ used for periodic testing	<input type="checkbox"/>
Final Written Exam	<input type="checkbox"/>
Final Skills Competency Exam	<input type="checkbox"/>
Statement verifying course content meets or exceeds the current standards and instructional guidelines established by the National Highway Traffic Safety Administration (NHTSA), Statement verifying CPR training taught to the curriculum standards of the American Heart Association (AHA) Basic Life Support (BLS) for Health Care Providers CPR/Automated External Defibrillator (AED) Program, or equivalent level.	<input type="checkbox"/>
Provisions to submit to YEMSA a Course Completion Graduate Roster to include: Name, Email, Mailing Address with City, State & Zip, and a Phone Number for each person receiving a Course Completion Certificate.	<input type="checkbox"/>
EMR Training Program Application Fee: (4 years)	<input type="checkbox"/>

¹ No more than five (5) students are to be assigned to one (1) individual during skills practice/laboratory.



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**EMERGENCY MEDICAL RESPONDER (EMR)
TRAINING PROGRAM APPLICATION FORM**

Name of Training Program:

Name of Institution: _____ Website: _____

Phone #: _____ Fax #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Program Contact: _____ Email: _____

Phone #: _____ Fax #: _____

Course Title: _____

Program Director: _____

Principal Instructor: _____

EMR Course(s):

Class Site Location: _____

Proposed Dates: _____

Classroom Hours: _____

Full Schedule Attached

Syllabus Attached

List Text(s): Title, Author, Copyright, & Date Revised/Edition



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PROGRAM DIRECTOR INFORMATION FORM

Program Director Name:

Occupation:

List Professional and/or Academic Degree(s) held:

List Professional License Number(s): (if applicable)

What California Teaching Credential(s) do you hold? (if any):

Type:

Expiration Date:

Type:

Expiration Date:

Administrative and/or Management Experience:

Course Content you will be teaching, by subject (if applicable):

I certify that all information on this form, to the best of my knowledge, is true and correct.

Signature of Program Director

Date

Attach documentation verifying at least forty (40) hours of education and experience in methods, materials and evaluation of instruction.

Attach a copy of the Program Director's current Driver's License



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PRINCIPLE INSTRUCTOR INFORMATION
PHYSICIAN (MD), PHYSICAN ASSISTANT (PA),
REGISTERED NURSE (RN), PARAMEDIC, OR
EMERGENCY MEDICAL TECHINCIAN (EMT) FORM
(ONE FORM FOR EACH INSTRUCTOR)

Principle Instructor Name:

Occupation:

List Professional and/or Academic Degree(s) held:

List Professional License Number(s): (if applicable)

What California Teaching Credential(s) do you hold? (if any):

Type:

Expiration Date:

Type:

Expiration Date:

Academic or Clinical Experience in Basic Life Support (BLS)/Advanced Life Support (ALS) Prehospital Care:
(minimum 2 years within the past 5 years)

Course Content you will be teaching, by subject (if applicable):

I certify that all information on this form, to the best of my knowledge, is true and correct.

Signature of Principle Instructor

Date

I certify that _____ is qualified to teach those sections of the course she/he is assigned.
Instructor Name

Signature of Program Director

Date

Attach documentation verifying at least forty (40) hours of education and experience in methods,
materials and evaluation of instruction.

Attach a copy of each Instructor's current Driver's License.



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TEACHING ASSISTANT INFORMATION FORM

(ONE FORM FOR EACH ASSISTANT)

Teaching Assistant Name:

Occupation:

List Professional and/or Academic Degree(s) held:

List Professional License Number(s): (if applicable)

What California Teaching Credential(s) do you hold? (if any):

Type:

Expiration Date:

Type:

Expiration Date:

Academic or Clinical Experience in Basic Life Support (BLS)/Advanced Life Support (ALS) Prehospital Care:

Course Content you will be teaching, by subject (if applicable):

I certify that all information on this form, to the best of my knowledge, is true and correct.

Signature of Teaching Assistant

Date

I certify that the Teaching Assistant _____ is qualified to teach those sections of the course she/he is assigned and will be supervised by a Principle Instructor, or the Program Director at all times.

Signature of Program Director

Date

Attach a copy of Teaching Assistant's current Driver's License.

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