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

EMERGENCY MEDICAL TECHNICIAN (EMT) TRAINING PROGRAM

APPLICATION PACKET FOR COURSE APPROVAL

EMERGENCY MEDICAL TECHNICIAN (EMT) PROGRAM ATTACHMENT CHECKLIST

MATERIALS TO BE SUBMITTED WITH APPLICATION:	ENCLOSED
EMT Training Program Application Form	☐
Program Director Information Form and Supporting Documents	☐
Program Clinical Coordinator Information Form and Supporting Documents	☐
Principal Instructor Information Form(s) and Supporting Documents for each Principal Instructor	☐
Teaching Assistant Information Form(s) and Supporting Documents for each Teaching Assistant	☐
Clinical Experience Provider Form[1] with Copies of Written Agreement(s)	☐
Class Site Location Form	☐
Description of Program Facilities, Equipment, Exam Security, and Student Record Keeping	☐
Lesson Plans and Objectives	☐
Course Schedule (include proposed dates)	☐
Samples of Written and Skills Exams[2] used for periodic testing	☐
Final Written Exam	☐
Final Skills Competency Exam	☐
Statement verifying usage of United States (U.S.) Department of Transportation's (DOT) EMT-Basic National Standard Curriculum, (DOT HS 808 149, August 1994 Curriculum), 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 is a prerequisite for admission to an EMT Course.	☐
Provisions for Course Completion by Challenge Exam, including Challenge Exam if different than Final Written Exam	☐
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.	☐
Sample of Course Completion Certificate	☐
Provisions for twenty-four (24) hour Refresher Course	☐
Provisions for Continuing Education Course(s) Provided	☐
Sample of Continuing Education (CE) Certificate	☐
EMT Training Program Application Fee: (4 years)	☐

[1] No more than three (3) students are to be assigned to one (1) individual during supervised clinical experience.
[2] No more than ten (10) students are to be assigned to one (1) individual during skills practice/laboratory.

EMERGENCY MEDICAL TECHNICIAN (EMT) 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:		
Program Clinical Coordinator:		
Principal Instructor:		

EMT/Refresher Course(s):	
Class Site Location:	Class Site Location:
Proposed Dates:	Proposed Dates:
Total Hours:	Total Hours:
Classroom Hours:	Classroom Hours:
Clinical Hours:	Clinical Hours:
Field Experience:	Field Experience:
Full Schedule Attached ☐	Full Schedule Attached ☐
Syllabus Attached ☐	Syllabus Attached ☐

Weeks:	
Semester:	Quarter:
Other (Specify):	
Units of Credit:	

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

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.

PROGRAM CLINICAL COORDINATOR INFORMATION FORM

Program Clinical Coordinator 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:

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 Program Clinical Coordinator *Date*

Signature of Program Director *Date*

☐ Attach a copy of Program Clinical Coordinator's current Driver's License.

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

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

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, the Program Clinical Coordinator or the program Director at all times.

Signature of Program Director *Date*

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

CLINICAL EXPERIENCE PROVIDER INFORMATION FORM

Please list the name(s) of your clinical providers with copies of your written agreement(s).

Name:		**Website:**
Mailing Address:		
City:	State:	Zip:
Contact Person:		Email:
Phone #:		Fax #:
Course Title:		☐ Attach copy of written agreement

Name:		**Website:**
Mailing Address:		
City:	State:	Zip:
Contact Person:		Email:
Phone #:		Fax #:
Course Title:		☐ Attach copy of written agreement

Name:		**Website:**
Mailing Address:		
City:	State:	Zip:
Contact Person:		Email:
Phone #:		Fax #:
Course Title:		☐ Attach copy of written agreement

Name:		**Website:**
Mailing Address:		
City:	State:	Zip:
Contact Person:		Email:
Phone #:		Fax #:
Course Title:		☐ Attach copy of written agreement

Name:		**Website:**
Mailing Address:		
City:	State:	Zip:
Contact Person:		Email:
Phone #:		Fax #:
Course Title:		☐ Attach copy of written agreement

(Please make more copies of this page as needed.)

APPLICATION TO TAKE THE EMERGENCY MEDICAL TECHINICIAN (EMT) CHALLENGE EXAMINATION FORM

Name:		**Email:**
Mailing Address:		
City:	State:	Zip:
Phone #:		

(Check those applicable)

An individual may obtain an EMT Course Completion record by successfully passing an approved course challenge examination if s/he meets one (1) of the following eligibility requirements:

- ☐ The person is a currently licensed Physician (MD) in one (1) of the states of the United States (U.S.), Registered Nurse (RN), Physician Assistant (PA), Licensed Vocational Nurse (LVN) or Paramedic.

- ☐ The person provides documented evidence of having successfully completed an emergency medical service training program of the Armed Forces including the U.S. Coast Guard within the preceding two (2) years, which meets the Department of Transportation EMT-I course guidelines. Upon review of documentation, the EMT Certifying Authority may also allow an individual to challenge, if the individual was active in the last two (2) years in a prehospital emergency medical classification of the Armed Services including the U.S. Coast Guard, which does not have formal recertification requirements. These individuals may be required to take a refresher course or complete continuing education courses as a condition of certification.

I certify that all information on this form, to the best of my knowledge, is true and correct and *I understand that I may take this examination only one (1) time.*

_________________________________ _________________________

Signature of Applicant *Date*

✪✪

To be completed by the Instructor:

Date examination taken: ☐Passed ☐Failed

_________________________________ _________________________

Signature of Primary Instructor *Date*

Training Institution:

This page was intentionally left blank