OFFICAL USE ONLY	
COURSE NUMBER	APPROVAL

APPLICATION FOR COURSE APPROVAL

(MUST BE SUBMITTED AT LEAST THIRTY (30) DAYS PRIOR TO CLASS START DATE)

Date: _____

CHECK ONE: ☐ **EMR** ☐ **EMT** ☐ **AEMT** ☐ **PARAMEDIC** ☐ **EMD** ☐ **VENTILATOR TRAINING**
☐ **COMMUNITY PARAMEDIC** ☐ **PARAMEDIC-CRITICAL CARE**

CHECK ONE: ☐ **INITIAL** ☐ **REFRESHER**

Please type or print

Sponsoring Institution: _____

Address: _____
Street City/Town State Zip

Program Director: _____ Contact Telephone#: _____

Email Address: _____

Campus Location: _____ Classroom Location: _____

Beginning Date: _____ Requested Practical Date: _____ Class Hours: _____ to _____

COPY OF CLASS SCHEDULE MUST BE SUBMITTED WITH THIS APPLICATION

Anticipated Enrollment: _____ (**NOT TO EXCEED 12 STUDENTS PER LAB SESSION PER INSTRUCTOR)**

Medical Director: _____ Lead Instructor/Coordinator: _____

Co- Instructors: _____

We jointly agree that the stated course will be conducted in accordance with the policies, standards and requirements as set forth in the EMS statutes, Rules and Regulations, and the Office of EMS Training Policy.

Signed: _____ Date: _____
(Program Director)

Signed:_____ Date:_____
(EMS Consultant)

PH-2792 (Rev 3-2019) RDA-10137

DIVISION OF HEALTH LICENSURE AND REGULATION • **OFFICE OF EMERGENCY MEDICAL SERVICES**
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