



### **INSTRUCTIONS FOR COMPLETING EMT COURSE APPROVAL PACKET**

In accordance with Title 22 of the California Code of Regulations, Chapter 2, Sections 100057 and 100069 agencies offering EMT training must secure program approval from the Local EMS Agency and must comply with the regulations set forth.

This packet has been prepared to assist you with the process. Please complete all of the forms which are enclosed and check them off on the "Applicant Check List" as they are completed. An explanation of the information needed is on the individual forms. For the items shown on the check list where there are not forms, it will be necessary to add the items as "Attachments."

Please document the following regarding your proposed training program:

- The name of the proposed sponsoring institution. (Please see Form #1)
- The type of course you propose to offer, EMT or EMT Recertification. (Please see Form #1)
- The reason the course is needed.
- The geographic area, groups and/or agencies this course would serve.
- Other EMT or EMT Recertification courses available within a reasonable distance.
- The impact upon the local community if this course is not approved.
- Proposed number, approximate date and location of full or recertification courses. (Please see Form #2)
- A statement that you agree to utilize the National Standard EMT Curriculum including the required learning objectives, skills protocols, and treatment guidelines.
- Your Course Outline which includes a calendar of what subject matter will be taught on specific dates. If you do not have specific dates, list the order of the material to be covered per session in chronological order.
- Samples of written and skills tests which includes copies of three (3) quizzes or periodic written examinations. If you are using skills examinations that are different than those in the Mountain-Valley EMS Agency Practical Examination Workbook then include three (3) samples of those skills examinations.
- Agreements for Clinical Experience - **Ten (10) hours of supervised clinical instruction in a general acute care hospital, operational ambulance provider or rescue vehicle provider is required.** Each approved EMT training program shall have written agreement(s) with one or more

of the above mentioned clinical settings. The written agreement(s) shall specify the roles and responsibilities of the training program and the clinical provider(s) for supplying the supervised clinical experience for the EMT student(s). Supervision for the clinical experience shall be provided by an individual who meets the qualifications of a principal instructor or teaching assistant. No more than three (3) students will be assigned to one (1) qualified supervisor during the supervised clinical experience. Please note that "three (3) patient or equivalent simulated patient contacts wherein a patient assessment and other EMT skills are performed" are required.

### **Additional Instructions/Information:**

#### **Skills/Procedures Which May Be Performed/Observed**

This form is provided as an example of a Student Clinical Documentation Form. You may duplicate it for your use if you wish. - Please see form #9

#### **Course Completion Notification**

Enclosed in your packet is Form #10. Please complete it immediately upon conclusion of your course and submit it to this agency. It is a necessary part of our process in preparing and issuing certifications.

#### **Example of Course Completion Certificate**

You may design your course completion certificate as you wish but please review this example, Form #11, carefully as the items shown on it are required by regulation (Section 100077) to be included on the Course Completion Certificate.

#### **Please note:**

Any changes that are made in the course schedule or to the instructional personnel must be reported to this agency in advance if possible or in all cases within 30 days of the change.

If you need more information or have questions please contact Cindy Murdaugh at (209) 529-5085 or [cmurdaugh@mvemsa.com](mailto:cmurdaugh@mvemsa.com)

## EMT Program Approval Applicant Checklist

Please review the Applicant Checklist prior to submitting your application for approval. For those items where there is no form, please submit an attachment noting the requested material.

Form #	Attachment	Item	For Agency Use Only
1		Name of Proposed Sponsoring Agency	
1		Proposed Type of Courses Offered	
		Reason for Course	
		Geographic Area/Group Served	
		Other Courses Available	
		Impact Upon Local Community	
2		Proposed Number, Dates and Location of Courses	
		Curriculum Utilized	
		Course Outline	
		Sample Written and Skills Exams	
		Clinical Agreements	
3		Name and Qualifications of Program Director	
4		Name and Qualifications of Program Clinical Coordinator	
5		Name and Qualifications of Program Principal Instructor	
6		Name and Qualifications of Program Teaching Assistants	
7		Provision for Challenge/Recertification Testing	
8		Course Exams	
		Clinical Instructions	
		Sample Course Completion Certificate	

**Mountain-Valley  
EMERGENCY MEDICAL SERVICES AGENCY**

EMT TRAINING PROGRAM

REQUEST FOR APPROVAL

SPONSORING AGENCY:

ADDRESS:

TELEPHONE:

TYPE OF COURSE OFFERED: *(please check)* Initial \_\_\_\_\_ Recertification \_\_\_\_\_

PROGRAM DIRECTOR: \_\_\_\_\_

CLINICAL COORDINATOR: \_\_\_\_\_

PRINCIPAL INSTRUCTOR: \_\_\_\_\_

# PROPOSED SCHEDULE OF EMT COURSES

Sponsoring Agency

Type of Course *	Date	Location	Time	Principal Instructor

\* Type of Course(s):

I = EMT Initial Course

R = EMT Refresher Course

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Date

Signature of Program Director

Please submit your proposed courses for the next four years. Any changes to your course schedule must be submitted in writing to the Mountain-Valley EMS Agency within 30 days of any change.

# EMT Training Program

## PROGRAM DIRECTOR

**Section 10070. (a) Qualifications-** Has completed a minimum 40-hour teaching methodology course which meets the requirements of the attached MVEMSA policy. **Duties-** In coordination with the Program Clinical Coordinator, shall include but not be limited to: **1.** Administration of the training program. **2.** Approval of course content. **3.** Approval of all written examinations and the final skills examination. **4.** Coordination of all clinical and field activities. **5.** Approval of principal instructor and teaching assistants. **6.** Signing of all course completion records. **7.** Assure that all aspects of the EMT training program is in compliance with Title 22, Chapter 2 of the California Code of Regulations.

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE (HOME): \_\_\_\_\_ (WORK): \_\_\_\_\_

### PROFESSIONAL / ACADEMIC DEGREE(S)

INSTITUTION	DEGREE	DATE COMPLETED

### EMERGENCY CARE / RELATED EDUCATION (LIST CURRENT CERTIFICATE (S) OR LICENSE(S))

INSTITUTION	COURSE/CERT OR LICENSE #	DATE COMPLETED

### EMERGENCY CARE / RELATED EXPERIENCE

ORGANIZATION	POSITION	DATES

### CALIFORNIA TEACHING CREDENTIAL(S)

TYPE OF CREDENTIAL	ISSUING AGENCY	

DATE

SIGNATURE OF PROGRAM DIRECTOR

Form #3  
EMT Training Program

**PROGRAM CLINICAL COORDINATOR**

**Section 10070. (b) Qualifications** - Shall be a physician, registered nurse, physician assistant or paramedic currently licensed in the State of California and shall have two (2) years academic or clinical experience in emergency medicine in the last five (5) years. **Duties** - Include but are not limited to: **1.** Responsibility for the overall quality of medical content of the program. **2.** Approval of qualifications of the principal instructor and teaching assistants.

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE (HOME): \_\_\_\_\_ (WORK): \_\_\_\_\_

**PROFESSIONAL / ACADEMIC DEGREE(S)**

INSTITUTION	DEGREE	DATE COMPLETED

**EMERGENCY CARE / RELATED EDUCATION (LIST CURRENT CERTIFICATE (S) OR LICENSE(S))**

INSTITUTION	COURSE/CERT OR LICENSE #	DATE COMPLETED

**EMERGENCY CARE / RELATED EXPERIENCE**

ORGANIZATION	POSITION	DATES

**CALIFORNIA TEACHING CREDENTIAL(S)**

TYPE OF CREDENTIAL	ISSUING AGENCY	EXPIRATION

Circle One > I Will / Will Not Be Teaching Portions of this Training Program. If Yes, List the Content of the Subject(s) You Will Teach.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Program Clinical Coordinator

## PROGRAM PRINCIPAL INSTRUCTOR

**Section 10070. (c) Qualifications** - Shall be a physician, registered nurse, physician assistant, EMT-P, EMT II, or EMT, who is currently licensed or certified in the State of California; have at least two (2) years academic or clinical experience in the practice of emergency medicine or prehospital care within the last five years; have completed a minimum of a 40-hour teaching methodology course which meets the requirements outlined in attached MVEMSA policy; be approved by the Program Director/Clinical Coordinator as qualified to teach the topics to which s/he is assigned. **Duties** - Teach no less than 50% of the didactic classroom hours of the topics assigned.

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE (Home): \_\_\_\_\_ (Work): \_\_\_\_\_

### PROFESSIONAL / ACADEMIC DEGREE(S)

INSTITUTION	DEGREE	DATE COMPLETED

### EMERGENCY CARE / RELATED EDUCATION (LIST CURRENT CERTIFICATE (S) OR LICENSE(S))

INSTITUTION	COURSE/CERT OR LICENSE #	DATE COMPLETED

### EMERGENCY CARE / RELATED EXPERIENCE

ORGANIZATION	POSITION	DATES

### CALIFORNIA TEACHING CREDENTIAL(S)

TYPE OF CREDENTIAL	ISSUING AGENCY	EXPIRATION

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of the Program Principal Instructor  
Form #5



# EMT Training Program

## PROGRAM TEACHING ASSISTANT

**Section 10070 (d) Qualifications** - Shall be qualified by training and experience to assist with teaching of the course and shall be approved by the Program Director in coordination with the Program Clinical Coordinator as qualified to teach assigned topics. **Duties** - Shall teach assigned topics and shall be supervised by a Principal Instructor, the Program Director and/or the Program Clinical Coordinator.

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE (Home): \_\_\_\_\_ (Work): \_\_\_\_\_

### PROFESSIONAL / ACADEMIC DEGREE(S)

INSTITUTION	DEGREE	DATE COMPLETED

### EMERGENCY CARE / RELATED EDUCATION (LIST CURRENT CERTIFICATE (S) OR LICENSE(S))

INSTITUTION	COURSE/CERT OR LICENSE #	DATE COMPLETED

### EMERGENCY CARE / RELATED EXPERIENCE

ORGANIZATION	POSITION	DATES

### CALIFORNIA TEACHING CREDENTIAL(S)

TYPE OF CREDENTIAL	ISSUING AGENCY	EXPIRATION

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of the Program Teaching Assistant  
Form #6

## PROVISION FOR CHALLENGE/RECERTIFICATION TESTING

An individual, who is eligible to challenge certification, as determined by the Mountain-Valley Emergency Medical Services Agency, may participate in the certifying written and skills proficiency examinations provided and scheduled for students enrolled in this course.

An individual who is eligible for recertification, as determined by the Mountain-Valley Emergency Medical Services Agency, may participate in the certifying written and skills proficiency examinations provided and scheduled for students enrolled in this course.

Verification of eligibility from the Mountain-Valley Emergency Medical Services Agency shall be required prior to testing.

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Name of Training Program

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Signature - Program Director

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Date

## COURSE EXAMINATIONS

### **FINAL SKILLS EXAMINATION**

*(Check the box which applies.)*

\_\_\_ A copy of my course final skills examination is enclosed.

\_\_\_ I will utilize the Mountain-Valley Emergency Medical Services  
Agency's EMT Skills Examination as my Final Skills Examination

### **FINAL WRITTEN EXAMINATION**

Please enclose a copy of your proposed course final.

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Name of Training Program

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Signature - Program Director

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Date

Dear Preceptor:

The following individual \_\_\_\_\_ is enrolled in the \_\_\_\_\_ EMT Training Program. In order to meet their course completion requirements, they must complete ten (10) hours of internship time on an ambulance, rescue vehicle or in a hospital. The student has been given basic information about what to expect but may need further briefing and orientation. Your assistance in helping them meet their clinical requirement is appreciated.

Listed on the back of this letter is a list of procedures. Please check those procedures that the individual observed while completing their internship. Also, please note where, when and with whom the student completed their internship. EMT Students Are Not Permitted to Practice Any Parenteral or Invasive Procedures.

EMT Students must be supervised during their clinical internship.

Please return this completed form to the individual so that they may receive credit for completing their clinical internship.

If you have any further questions regarding your role as a preceptor, please contact me at \_\_\_\_\_.

Sincerely,

Clinical Director or Instructor

## DOCUMENTATION OF EMT INTERNSHIP

This is to verify that the previously mentioned individual observed the following skills while completing their internship:

### SKILL

### OBSERVED

Administration of Oxygen  
Artificial Ventilation (Bag-Valve-Mask)  
Cardiac monitor/EKG - setup/attachment  
Cardiopulmonary resuscitation  
Control of external hemorrhage  
Defibrillation  
Emergency Childbirth  
Endotracheal or nasotracheal intubation  
Immobilizing of skeletal/spinal injuries  
Injection, intramuscular/subcutaneous  
Intravenous catheter placement  
Patient Assessment  
Sterile techniques  
Suctioning of the airway  
Triage  
Use of nasopharyngeal and oropharyngeal airway  
Vital Signs - assessment and monitoring  
Wound dressing/bandaging  
Other skills: (please note)

\_\_\_\_\_  
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### DOCUMENTATION OF INTERNSHIP HOURS:

DATE	LOCATION OF INTERNSHIP	HOURS	PRECEPTORS SIGNATURE

# EMERGENCY MEDICAL TECHNICIAN - I

## Notification of Course Completion Certificates Issued

Training Agency \_\_\_\_\_

NAME	TYPE OF COURSE *	DATE COURS E COMP.	ELIGIBLE FOR CERT YES NO		COMMENTS

\* I = EMT  
R = Refresher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Program Director  
Form #10

\_\_\_\_\_  
NAME OF TRAINING PROGRAM

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
Certifies That

\_\_\_\_\_  
Has successfully completed an  
Emergency Medical Technician - I Course  
on \_\_\_\_\_

This course has been approved by the  
Mountain-Valley EMS Agency  
pursuant to provisions of Division 2.5 of  
the California Health and Safety Code and Section  
100066 et. seq. of Title 22 of the California Code  
of Regulations.

\_\_\_\_\_  
Program Instructor

\_\_\_\_\_  
Program Director

**THIS IS NOT AN EMT CERTIFICATE**

**This Course Completion Record Is Valid to Apply for Certification for a  
Maximum of Two (2) Years from the Course Completion Date and Shall Be  
Recognized Statewide.**

The above form is provided as an example. The following information must be included on an EMT Course Completion Certificate:

1. The name of the individual.
2. The date of course completion.
3. The type of EMT course completed, EMT or Refresher, and the number of hours completed.
4. The EMT Approving Authority.
5. The signature of the Program Director.
6. The name and location of the training program issuing the record.
7. The following statements in **Bold** print:

**"THIS IS NOT AN EMT CERTIFICATE"**

**"This Course Completion Record Is Valid to Apply for Certification for a Maximum  
of Two (2) Years from the Course Completion Date and Shall Be Recognized  
Statewide."**