

EMT CONTINUING EDUCATION TRAINING PROGRAM APPLICATION

- 1. Date of Application: _____ 2. Telephone Number of Program Coordinator: _____
- 3a. Enter, in the box below, name and address of Program Coordinator receiving approved application.

[Empty box for name and address of Program Coordinator]

3.b. e-mail address of contact person

@ _____

- 4. Title of program: _____ *(attach course outline)*
- 5. Type of Program *(check the categories that apply to program submission):*

- (a) Mandatory refresher: Basic Intermediate Paramedic level
- (b) M & M Conference (ALS)
- (c) Continuing education EMT level (s) and hours requested:
 Basic: ___ hrs. Intermediate: ___ hrs. Paramedic: ___ hrs.

- 6. (a) Program date(s): _____ (b) Class time(s): from _____ to _____
- 7. (a) Total number of sessions: _____ (b) Total class hours: _____
- 8. Program location (specific address): _____
- 9. Primary Instructor's Name: _____ Address: _____

(Please list additional instructors on attached outline)

- 10. Will this program be open to EMTs outside your agency/department: Yes No
- 11. The Program Coordinator hereby affirms that the information on this application is true and correct and that the course will conform with the standards set forth in the outline.
Print name: _____ Signature: _____ Date: _____

NOTE: *The application and program outline must be submitted to appropriate agency at least 6 weeks prior to the program start date. OEMS will approve Region recommended courses within three weeks after receipt. No program can begin or be advertised as approved prior to receiving an OEMS approval number.*

- (REGION USE ONLY)** (if a Region or Region personnel participate in the training program, OEMS must review & approve)
- 12. The Regional training committee recommends program, does not recommend program.
 Recommends with changes as noted Region _____
- Program reviewed by: _____
Date _____ Print Name / Title _____ Authorized Signature _____

- (OEMS USE ONLY)**
- 13. Program meets the requirements for: Continuing Education _____ Basic hrs.
 _____ Level Refresher _____ Intermediate hrs.
 ALS M&M Conference _____ Paramedic hrs.
 The Program does not meet requirements for approval *(explanation attached).*
- _____
Date _____ Print Name / Title _____ Authorized Signature _____

OEMS APPROVAL NUMBER

INSTRUCTIONS FOR COMPLETING CONTINUING EDUCATION PROGRAM APPLICATION

Item 1. Enter the date application is completed.

Item 2. Provide telephone number where Program Coordinator may be contacted during normal business hours. This telephone number will be made available to EMT's for programs that indicate they are open to the public.

Item 3a. Provide the complete mailing address where you wish approval number mailed. This should be either Program Coordinator or Sponsoring Institution's address. It is important that information provided in this box be **accurate and readable**. This address will appear in the return envelope window with your approved application.

Item 3b. Provide e-mail address of Program Coordinator in case OEMS needs to reach you quickly.

Item 4. Write a short title that accurately depicts the nature of program. Example: "EMT-Basic Refresher", "Spine Immobilization" etc. You must attach a detailed program outline that identifies the learning objectives, program content, teaching plan/methods, time frames, written and/or practical skills tests, evaluation tool, etc. if applicable.

Item 5. Identify the Type of Program and complete the appropriate section. There are three (3) program classifications: (A) Refresher Training, (B) Morbidity and Mortality Rounds or, (C) Continuing Education. Indicate continuing education hours requested and EMT level.

Item 6. Indicate (a) date(s) and (b) times program will be offered. Make clear exactly when each session will take place. Indicate if the program will be offered to several shifts at different times.

Item 7. (a) Indicate total class meetings (sessions) and (b) total class hours. Only actual instructional time will count. Time allotted for breaks and lunch will not be counted for recertification credit hours.

Item 8. Identify the location where the program will take place. Be specific: hospital, teaching institution, fire station, etc.. Name of city or town, street and room number.

Item 9. Identify name and address of primary instructor (even if you are the primary instructor). Include background references such as "EMT", "I/C", "RN", "MD", etc.. Identify additional instructors along with their credentials (include resume information for each) on attached course outline.

Item 10. Check "Yes" if the program is open to the general EMT population. Check "No" if the program is being offered to a limited audience. OEMS receives inquiries as to location and time of continuing education programs and periodically publishes continuing education program resources on web-site.

Item 11. Program Coordinator will print full name and write signature indicating they will conduct training program in conformance with application and program outline standards.

Please fill in the e-mail address if applicable, this will aid in future program communication and coordination.

Note: *The application must be submitted at least six weeks prior to program start date. This will allow time for review, processing and mailing of approval documentation. Please take the processing time into consideration when developing program schedules. No program can begin or be advertised as approved prior to receiving an OEMS approval number.*

Item 12. (For Regional Training Committee use only). Note: Region sponsored programs must be reviewed (submit all applicable documentation) and approved by OEMS. Check applicable box either recommended or not recommended. If not recommended, attach written explanation and return to originator. Check box and fill in region number indicating which Region is reviewing / recommending application. Indicate date review was completed, name, title and signature of reviewing authority.

Item 13. (For OEMS use only) Indicate EMT program level and hours approved. Indicate date review was completed, name, title and signature of reviewing authority. Attached explanation and return to originator if not approved.