PARAMEDIC SKILLS MAINTENANCE FORM

INSTRUCTIONS FOR THE NAPA COUNTY INFREQUENTLY USED SKILLS MAINTENANCE FORM

1 Name of License Holder

Provide the complete name of the paramedic who is demonstrating skills competency.

2 License Number

Provide the paramedic license number of the paramedic who is demonstrating skills competency.

3 Signature

Signature of the paramedic who is demonstrating competency. By signing this section the paramedic is verifying that the information contained on this form is accurate and that he/she has demonstrated competency in the skills listed to a qualified instructor.

Verification of Competency

1 Agency Affiliation

Name of the training program or EMS service provider authorizing the qualified individual who is verifying competency.

2 Date

Enter the date that the individual demonstrates competency for the skill that is being evaluated.

3 Signature of Person Verifying Competency

Signature of the individual verifying competency of the skill once the competency has been demonstrated by direct observation of an actual or simulated patient contact.

Individuals qualified to verify skills competency shall be a currently licensed Paramedic, Registered Nurse, Physician Assistant, or Physician and shall be either a qualified instructor designated by an EMS approved training program (paramedic training program or continuing education training program) or by a qualified individual designated by an EMS service provider. EMS service providers include, but are not limited to, public safety agencies, private ambulance providers and other EMS providers. The emergency department physician is qualified to verify a skill completed in the field.

4 Print Name

Print the name of the individual verifying competency of the skill.

5. Certification/License Number:

Provide the profession and license number of the individual verifying competency. (e.g. P19553)

PARAMEDIC SKILLS MAINTENANCE FORM

Name: _____ **License Number:** _____

I certify, under the penalty of perjury, that the information contained on this form is accurate.

Signature: _____ **Date:** _____

Skill	Verification of Completion
VENTILATORY MANAGEMENT/ENDOTRACHEAL INTUBATION	**Date**:
Agency Affiliation:	HVL ☐ DL with Bougie ☐
Signature of Person Verifying Competency:	Print Name:
	License Number:
VENTILATORY MANAGEMENT/ENDOTRACHEAL INTUBATION	**Date**:
Agency Affiliation:	HVL ☐ DL with Bougie ☐
Signature of Person Verifying Competency:	Print Name:
	License Number:
VENTILATORY MANAGEMENT/ENDOTRACHEAL INTUBATION	**Date**:
Agency Affiliation:	HVL ☐ DL with Bougie ☐
Signature of Person Verifying Competency:	Print Name:
	License Number:
VENTILATORY MANAGEMENT/ENDOTRACHEAL INTUBATION	Date:
Agency Affiliation:	HVL ☐ DL with Bougie ☐
Signature of Person Verifying Competency:	Print Name:
	License Number:
VENTILATORY MANAGEMENT/ENDOTRACHEAL INTUBATION	**Date**:
Agency Affiliation:	HVL ☐ DL with Bougie ☐
Signature of Person Verifying Competency:	Print Name:
	License Number:
VENTILATORY MANAGEMENT/ENDOTRACHEAL INTUBATION	**Date**:
Agency Affiliation:	HVL ☐ DL with Bougie ☐
Signature of Person Verifying Competency:	Print Name:
	License Number: