APPROVAL PACKET

for

Emergency Medical Technician (EMT) Training Program

Emergency Medical Technician (EMT) Training Program

Approval Packet

California regulations require OCEMS to review prospective training programs to assure compliance with State regulations prior to approving the eligible institution's training program. Only approved training programs may offer the training listed below. The purpose of this document is to define the application requirements for the Emergency Medical Technician (EMT) Training Program.

REQUIREMENTS FOR EMT TRAINING PROGRAM APPROVAL:

The eligibility and program requirements for Emergency Medical Training Programs are listed in the California Code of Regulations (COR), Title 22. Social Security, Division 9. Prehospital Emergency Medical Services, Chapter
2. Emergency Medical Technician, Article 3. Sections 100065 - 100078 and referenced in the attached application and checklist.

Complete and submit OCEMS EMT Training Program approval forms and checklist for EMT Training Program Approval.

EMT TRAINING PROGRAM

I. PROCEDURES

A. Complete and submit the following to OCEMS:
- Application for EMT Training Program Approval
- Applicable Fees
- Checklist for EMT Training Program Approval
- Hospital/Ambulance Affiliation Information Form

B. The following should be retained by the Training Institution:
- Certification Exam, i.e., passing grade.
- Attendance Requirements, etc.
- Certification Exam Eligibility, Clinical Time Verification Form

Application for EMT Training Program Approval

☐ New ☐ Renewal ☐ Update

Program Name _____

Mailing Address _____ **City** _____ **ST** _____ **ZIP** _____

Website _____

Program Director _____

E-Mail Address _____ **Phone Number** _____

License Number _____ **License Type** _____

Clinical Coordinator _____

E-Mail Address _____ **Phone Number** _____

License Number _____ **License Type** _____

Training Site #1 Address _____ **City** _____ **ST** _____ **ZIP** _____

Is this Training Site 100% In-Classroom or Hybrid _____

If Hybrid, provide the number of hours in each: **In-Classroom** _____ **Online** _____

Principal Instructor For This Site _____ **Phone Number** _____

E-mail _____

License Number _____ **License Type** _____

Teaching Assistant _____ **Title** _____

E-mail _____

License Number _____ **License Type** _____

Training Site #2 Address _____ **City** _____ **ST** _____ **ZIP** _____

Is this Training Site 100% In-Classroom or Hybrid _____

If Hybrid, provide the number of hours in each: **In-Classroom** _____ **Online** _____

Principal Instructor For This Site _____ **Phone Number** _____

E-mail _____

License Number _____ **License Type** _____

Teaching Assistant _____ **Title** _____

E-mail _____

License Number _____ **License Type** _____

Training Site #3 Address _____ **City**_____ **ST** _____**ZIP**_____

Is this Training Site 100% In-Classroom or Hybrid _____

If Hybrid, provide the number of hours in each: **In-Classroom**_____ **Online** _____

Principal Instructor For This Site_____ **Phone Number**_____

E-mail _____

License Number _____ **License Type** _____

Teaching Assistant _____ **Title** _____

E-mail _____

License Number _____ **License Type** _____

Include evidence of 40 hours in teaching methodology instruction in areas related to methods, materials, and evaluation of instruction.

Attach the required documents for all principal instructors as indicated in COR, Title 22, Division 9, Chapter 2, Section 100070.

Attach qualifications for teaching assistants.

Use a separate page for additional principal instructor(s) and teaching assistant(s). Attach Hospital and EMS Service Provider Contracts for clinical and field training.

Provider type *(check one):*

- ☐ Branch of the Armed Forces
- ☐ College or University
- ☐ Licensed acute care hospital
- ☐ Public safety agency
- ☐ Private post-secondary school
- ☐ School District/ROP
- ☐ Other: Specify

Textbook Name and Edition _____

List Below the Other Types of Teaching Materials you are Using for your EMT Program

1. _____
2. _____
3. _____
4. _____
5. _____

I certify that all information is accurate, to the best of my knowledge, and that I have read and understand the program responsibilities and expectations as outlined in COR, Title 22, Division 9, Chapter 2 (Emergency Medical Technician).

Signed, Program Director

Date

(OCEMS Use Only)

Date Application Received	Approval Date	Expiration Date	Receipt # / Date Paid

CHECKLIST FOR EMT TRAINING PROGRAM APPROVAL

	Materials to Submit for Program Approval	Page No.	Check Completed
1.	Table of Contents and checklist listing required information with corresponding page numbers (this form)		☐
2.	Application form for EMT training program approval		☐
3.	Statement of eligibility for training program approval (e.g., Accredited University, Community College, School District, Vocational Program. Private Post-Secondary School)		☐
4.	A written request to OCEMS for EMT training program approval		☐
5.	A statement verifying course content is equivalent to the US DOT National Emergency Medical Services Education Standards Emergency Medical Technician Instructional Guidelines (DOT HS 811 077A, January 2009). Statement of what curriculum would be used, listing textbook(s) and year(s) of publication.		☐
6.	Schedule of courses and method by which they will be taught (Full Classroom, Hybrid)		☐
7.	Statement verifying CPR training equivalent to the current American Heart Association Guidelines at the Healthcare Provider level		☐
8.	Statement that written final examination, chapter examinations and quizzes are kept on file and available for review.		☐
9.	Submit individual skills competency and final skills competency examinations.		☐
10.	Name and qualifications of the program director, program clinical coordinator, and principal instructor(s)		☐
11.	Evidence the course/program director and principal instructor have completed 40 hours in teaching methodology or equivalent per COR, Title 22, Division 9, Chapter 2, §100070		☐
12.	Provisions for course completion by challenge, including a challenge examination (if different from the final examination)		☐
13.	Provisions for a 24-hour refresher required for renewal or reinstatement		☐
14.	Statement verifying usage of the US DOT EMT - Basic Refresher National Standard Curriculum (DOT HS 808 624, September 1996)		☐
15.	Address of where the EMT program is located and where courses will be taught. (If the program has multiple locations, page 3 of this application must be completed for each location)		☐
16.	Copy of written agreement with 1 or more acute care hospital(s) or operational ambulance provider(s) to provide clinical experience		☐
17.	Application fees		☐

REQUIRED SUPPLIES FOR EMT TRAINING PROGRAM

REQUIRED SUPPLIES FORM TO BE COMPLTED BY OCEMS PERSONNEL

Required Supplies with Quantities		Check Completed
BSI Materials	☐ Gloves (1 Pair) ☐ Surgical Masks (1) ☐ N95s (1) ☐ Disposable Gowns (**1**) ☐ Goggles/Glasses (1)	☐
Spinal Immobilization Devices	☐ Adult C-Collar (Either Adjustable or 1 of Each Size) ☐ Pediatric C-Collar (I) ☐ Head Immobilizer (1) ☐ KED Device (1) ☐ Backboard with Straps (I)	☐
Trauma	☐ Trauma Tag (1)	☐
Airway Adjuncts	☐ Nasopharyngeal Airway Adjuncts (No Less the 4 Standard Sizes) ☐ Oropharyngeal Airway Adjuncts (1 of Each Size, Sizes 0-5) ☐ Water-Soluble Lubricant (1)	☐
Oxygen	☐ Adult BVM **(1)** ☐ Pediatric BVM (1) ☐ Infant BVM (1) ☐ Adult, Pediatric, & Infant Oxygen Non-Rebreather Masks (1 of Each) ☐ Adult & Pediatric Nasal Cannulas (1 of Each) ☐ Oxygen Cylinder & Regulator (1 of Each)	☐
Vital Signs	☐ Adult, Pediatric, and Infant Blood Pressure Cuff (1 of Each) ☐ Stethoscope (1) ☐ Training Glucometer (1) ☐ Pulse Oximeter (**1**) ☐ Pen Light (**1**) ☐ Thigh Blood Pressure Cuff (1) ***OPTIONAL***	☐
Suction Equipment	☐ Mechanical Portable Suction Device (1) ☐ Tubing (1) ☐ Yankauer (1) ☐ Suction Catheter (1) ****OR**** ☐ Manual Portable Suction Device (1) ☐ Suction Catheter Attachment (1)	☐
CPR&AED	☐ Adult & Infant CPR Manikin (1 of Each, Either Mechanical or Manual) ☐ AED Trainer with Adult & Pediatric AED Pads (1) ☐ Towel (1) ☐ Training Razor (1)	☐

REQUIRED SUPPLIES FOR EMT TRAINING PROGRAM

REQUIRED SUPPLIES FORM TO BE COMPLTED BY OCEMS PERSONNEL

Required Supplies		Check Completed
Hemorrhage Control	☐ 4" x 4" Dressings (1) ☐ Roller Gauze or Kerlix (1) ☐ Petroleum Gauze (1) ☐ Arterial Tourniquet (1) ☐ Triangular Bandage (1) ☐ 1", 2", 3" Tape (1 of Each) ☐ Trauma Sheers (1) ☐ Arm, Leg, and Wrist Cardboard Splint (1 of Each) ☐ Cold Pack, or Simulated Equivalent (1) ☐ Burn Blanket (1) ☐ Standard Blanket (1) ☐ Biohazard Bag (1)	☐
Epinephrine & Naloxone	☐ Epinephrine Auto-Injector Training Device (1) ☐ Naloxone Auto-Injector Training Device **(1)** ☐ Sharps Container (1)	☐
Obstetrical	☐ Obstetrical Kit (1) ☐ Bulb Syringe (1) ☐ Baby Blanket (1) ☐ Towel (1) ☐ Umbilical Cord Clamps (1) ☐ Umbilical Cord Scissor (1) ☐ Breslow Tape (1) ☐ Childbirth Manikin ***OPTIONAL***	☐
Traction Splint	☐ Adult Traction Splint (1) ☐ Pediatric Traction Splint (1)	☐
Ambulance Cot **OPTIONAL**	☐ Mechanical Ambulance Cot ***OPTIONAL*** ☐ Manual Ambulance Cot ***OPTIONAL***	☐
Manikin **OPTIONAL**	☐ Full Size Manikin ***OPTIONAL***	☐

EMT TRAINING PROGRAM HOSPITAL/AMBULANCE AFFILIATION INFORMATION

(ATTACH SIGNED AGREEMENT)

Name(s) of general acute care hospital(s) providing supervised in-hospital clinical experience for the EMT student.

Name: _____

Address: _____

County: _____

Liaison: _____

Title: _____ Phone _____

E-mail: _____

Name: _____

Address: _____

County: _____

Liaison: _____

Title: _____ Phone: _____

E-Mail _____

Name(s) of ambulance provider agencies providing supervised instruction on an operational ambulance for the EMT student:

Level of Service

Name #1: _____ ☐ ALS ☐ BLS

Address: _____

County: _____

Liaison: _____

Title: _____ Phone: _____

E-Mail: _____

Level of Service

Name #2: _____ ☐ ALS ☐ BLS

Address: _____

County: _____

Liaison: _____

Title: _____ Phone: _____

E-Mail: _____

Name #3: _____ ☐ ALS ☐ BLS

Address: _____

County: _____

Liaison: _____

Title: _____ Phone: _____

E-Mail: _____

Level of Service

Name #4: _____ ☐ ALS ☐ BLS

Address: _____

County: _____

Liaison: _____

Title: _____ Phone: _____

E-Mail: _____