INLAND COUNTIES EMERGENCY MEDICAL AGENCY

Serving

San Bernardino, Inyo & Mono Counties

APPROVAL PACKET

for

Advanced Emergency Medical Technician (AEMT) Training Program

1425 South "D" Street • San Bernardino, CA • 92415-0060
909.388.5823 (Office) • 909.388.5825 (FAX)

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California regulations require ICEMA 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 Advanced Emergency Medical Technician (AEMT) Training Program approval.

REQUIREMENTS FOR ADVANCED EMT TRAINING PROGRAM APPROVAL:

The eligibility and program requirements for Advanced Emergency Medical Training Programs are listed in California Code of Regulations, Title 22. Social Security, Division 9. Prehospital Emergency Medical Services, Chapter 2. Advanced Emergency Medical Technician, Article 3. Sections 100101 - 100130 and referenced in the attached application and checklist.

Complete and submit ICEMA AEMT Training Program approval forms and checklist for AEMT Training Program Approval.

AEMT TRAINING PROGRAM

I. PROCEDURES

A. Complete and submit the following to ICEMA:
- Application for AEMT Training Program Approval
- Applicable Fees (See ICEMA Fee Schedule)
- Checklist for AEMT 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

C. Submit to ICEMA after completion of each course:
- The ICEMA approved Training Course Completion Record must be submitted within 15 days of course completion, typed or printed, and alphabetized.

D. Submit to ICEMA by July 15 each year:
- Summary of Training Program Student Completion

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CHECKLIST FOR AEMT 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 AEMT program approval		☐
3.	Statement of eligibility for program approval		☐
4.	Written request to ICEMA for AEMT training program approval		☐
5.	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)		☐
6.	A course outline		☐
7.	Performance objectives for each skill		☐
8.	Provisions for supervised hospital clinical training, including standardized forms for evaluating Advanced EMT trainees.		☐
9.	Provisions for supervised field internship, including standardized forms for evaluating Advanced EMT trainees.		☐
10.	Evidence that the program provides adequate facilities, equipment, examination security, student record keeping, clinical training and field internship training.		☐
11.	Samples of written and skills examinations used for periodic testing		☐
12.	Final skills competency examination		☐
13.	Final written examination		☐
14.	Name and qualifications of the course director, program clinical coordinator, and principal instructor(s)		☐
15.	Evidence the course director and principal instructor (s) have completed 40 hours in teaching methodology or equivalent per COR Title 22, Division 9, Chapter 3, §100109 (b) and (c6)		☐
16.	Provisions for course completion by challenge, including a challenge examination (if different from final examination)		☐
17.	Location where courses are to be offered and the proposed dates		☐
18.	Application fees		☐
19.	Copy of written agreement with 1 or more acute care hospital(s) to provide clinical experience as well as a clinical preceptor(s) to instruct and evaluate the student		☐
20.	Copy of written agreement with an Advanced EMT or Paramedic service provider (s) to provide for field internship and provide a field preceptor(s) to directly supervise, instruct and evaluate students.		☐

ICEMA STAFF USE ONLY

Comments: _____

_____

_____

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Application for AEMT Training Program Approval

☐ New ☐ Renewal ☐ Update ☐ Transition Course

Program Name _____

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

Training Site(s) Address _____ **City** _____ **ST** _____ **ZIP** _____

Phone _____ **FAX** _____

Website _____ **Email** _____

Course Director _____ **Title** _____

Email _____

License Number _____ **Type** _____

Include evidence of 40 hours in teaching methodology or equivalent per COR Title 22, Division 9, Chapter 2, §100150 (C5)

Clinical Coordinator _____ **Title** _____

Email _____

License Number _____ **Type** _____

Principal Instructor _____ **Title** _____

Email _____

License Number _____ **Type** _____

Include evidence of 40 hours in teaching methodology or equivalent per COR Title 22, Division 9, Chapter 2, §100150 (C5)

Teaching Assistant _____ **Title** _____

Email _____

License Number _____ **Type** _____

Teaching Assistant _____ **Title** _____

Email _____

License Number _____ **Type** _____

Attach copies of current resumes, CVs, licenses and qualifications for all personnel.

Attach Hospital and EMS Service Provider Contracts for clinical and field training.

Provider type *(check one)*	**Type of Training Offered (Check all that apply)**
☐ Branch of the Armed Forces	☐ First Responder (for high school students)
☐ Accredited College or University	☐ EMT Basic / Initial Training
☐ Licensed general acute care hospital	☐ AEMT Basic / Initial Training
☐ Public safety agency	☐ NREMT Transition Course
☐ Private post-secondary school	☐ EMT Refresher Course
☐ Other: Specify _____	☐ EMT-P Training Course
	☐ Continuing Education (CE) classes
	☐ Other (CPR etc.) _____

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 CA Code of Regulations, Title 22, Division 9, Chapter 3 (Advanced Emergency Medical Technician).

_____ _____

Signed, Course Director Date

(ICEMA Use Only)

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

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AEMT TRAINING PROGRAM
STUDENT PERFORMANCE DOCUMENTATION
CLINICAL TIME VERIFICATION
Clinical Internship/Hospital

TO BE COMPLETED BY CLINICAL EVALUATOR:

Student Name: _____

Hospital Name: _____

Date: _____ Time In: _____ Time Out: _____

INITIAL APPROPRIATE BOX	Above Satisfactory	Satisfactory	Unsatisfactory
Appearance			
Dependability			
Initiative/Cooperation			
Knowledge of Required Skills			
Follows Directions			
Attitude and Courtesy Towards Patients and Staff			
Safety Precautions			
Appropriate Use of Tools and Equipment			

***Any rating marked "Unsatisfactory" must be explained in the comment section below.**

COMMENTS: _____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Evaluator Signature of Student

THIS FORM IS TO BE KEPT ON FILE AT THE TRAINING INSTITUTION AND MUST BE SUBMITTED TO ICEMA UPON REQUEST

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HOSPITAL/AMBULANCE AFFILIATION INFORMATION

(ATTACH SIGNED AGREEMENT)

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

Name: _____

Address: _____

County: _____

Liaison: _____

Title: _____ Phone: _____

Email: _____

Name: _____

Address: _____

County: _____

Liaison: _____

Title: _____ Phone: _____

Email: _____

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

Level of Service

Name: _____ ☐ ALS ☐ BLS

Address: _____

County: _____

Liaison: _____

Title: _____ Phone: _____

Email: _____

Name: _____ ☐ ALS ☐ BLS

Address: _____

County: _____

Liaison: _____

Title: _____ Phone: _____

Email: _____

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AEMT TRAINING PROGRAM
NOTIFICATION OF PROPOSED COURSE

PROVIDER NAME: _____

Address: _____

Location of Instruction: _____

County: _____

Address (if different): _____

INSTRUCTOR NAME: _____ Phone: _____

Email: _____

COURSES SCHEDULED:

☐ Basic Fee $ _____

☐ Refresher Fee $ _____

_____ _____
Course Starting Date Course Completion Date

_____ _____
Date of Written Certifying Exam Date of Skills Certifying Exam:

Submitted by: _____
Name (Course Director)

_____
Signature Date

NOTE: This notification should be submitted to ICEMA not less than thirty (30) days before the start of the course. The Course Director, Clinical Coordinator, Principal Instructor and Teaching Assistant Information must either be on file at ICEMA or attached to this form prior to the start of the course. All instructors must be approved by ICEMA prior to the start of any course.

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ADVANCED EMERGENCY MEDICAL TECHNICIAN
COURSE COMPLETION RECORD

TYPE OF COURSE: ☐ Basic ☐ Refresher

Training Program Name: _____ Course No.: _____

Location Address & City: _____

Date of Course Completion: _____

TO BE COMPLETED BY PRINCIPAL INSTRUCTOR: I hereby certify that the persons whose names are listed below successfully completed the ICEMA approved Advanced EMT course and that the individuals participating in the final/certifying examination did so after verification of completion of all modules of the course by my signature. I have informed the class of ICEMA's Online Credentialing System to apply for AEMT Certification, and have distributed the current policy Reference #1010 - AEMT Certification to each student.

_____ _____
Skills Examination Date Written Examination Date

_____ _____
Principal Instructor Signature Date

TO BE COMPLETED BY PROGRAM DIRECTOR OR DESIGNEE: I hereby certify that the persons whose names are listed below successfully completed the ICEMA approved Advanced EMT course and were issued a tamper resistant AEMT course completion certificate and that these records concur with the records of the training program.

_____ _____
Program Director/Designee Signature Date

PRINT OR TYPE NAMES ALPHABETICALLY:

LAST	FIRST	ADDRESS	DATE CERTIFICATE ISSUED

Submit to ICEMA within 15 days after completion of the course.

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LAST	FIRST	ADDRESS	DATE CERTIFICATE ISSUED

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LAST	FIRST	ADDRESS	DATE CERTIFICATE ISSUED

Submit to ICEMA within 15 days after completion of the course.

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TRAINING AND CONTINUING EDUCATION
STUDENT RECAP

TRAINING PROGRAM INFORMATION

Name: _____

CE Provider No.: _____

Mailing Address: _____

Training Site(s) Address: _____

Program Director: _____ E-mail: _____

REPORTING YEAR (July 1 - June 30): _____ to _____

The following report must be submitted to ICEMA by all training programs and continuing education providers by July 15 each year whether or not any courses or CEs were provided.

Program Level (total number of students completing training in reporting year):

Emergency Medical Technician (EMT)

New: _____
Renewal: _____
Update: _____

Emergency Medical Technician-Paramedic (EMT-P)

New: _____
Renewal: _____
Update: _____
NREMT Transition: _____

Advanced Emergency Medical Technician (AEMT)

New: _____
Renewal: _____
Update: _____

Mobile Intensive Care Nurse (MICN)

New: _____
Renewal: _____
Update: _____

Public Safety First Aid (PSFA)

New: _____
Renewal: _____
Update: _____

Continuing Education

All CE Courses (not included above):

_____