INLAND COUNTIES EMERGENCY MEDICAL AGENCY

Serving

San Bernardino, Inyo & Mono Counties

APPROVAL PACKET

for

Emergency Medical Technician (EMT) Training Program

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

Emergency Medical Technician (EMT) Training Program

Approval Packet

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 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 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 ICEMA EMT Training Program approval forms and checklist for EMT Training Program Approval.

REQUIREMENTS FOR EMS CONTINUING EDUCATION APPROVAL:

Approved EMT training programs shall also receive approval as a continuing education (CE) provider effective the same date as the EMT training program approval. The CE program expiration date shall be the same expiration date as the EMT training program. The CE provider shall comply with all the requirements contained in Code of Regulations, Title 22, Chapter 11, Division 9, Chapter 11, Sections 100390 - 100395.

EMT TRAINING PROGRAM

I. PROCEDURES

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

C. Submit to ICEMA after completion of each course:
- The ICEMA approved Training Course 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

Application for EMT Training Program Approval

☐ **New** ☐ **Renewal** ☐ **Update**

Program Name _____

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

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

Phone _____ **FAX** _____

Website _____ **E-mail** _____

Program Director _____ **Title** _____

E-mail _____

License Number _____ **Type** _____

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

Clinical Coordinator _____ **Title** _____

E-mail _____

License Number _____ **Type** _____

Principal Instructor _____ **Title** _____

E-mail _____

License Number _____ **Type** _____

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

Teaching Assistant _____ **Title** _____

E-mail _____

License Number _____ **Type** _____

Attach qualifications for teaching assistants.

Use 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 _____

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), and Chapter 11 (EMS Continuing Education).

_____ _____

Signed, Program Director Date

(ICEMA Use Only)

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

CHECKLIST FOR EMT TRAINING PROGRAM APPROVAL

Revised 06/09/17

	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		☐
4.	Written request to ICEMA for EMT 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.	Statement verifying CPR training equivalent to the current American Heart Association Guidelines at the Healthcare Provider level		☐
7.	Samples of written and skills examinations used for periodic testing		☐
8.	Final skills competency examination		☐
9.	Final written examination		☐
10.	Name and qualifications of the program director, program clinical coordinator, and principal instructor(s)		☐
11.	Evidence the course/program director has 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 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.	Location where courses are to be offered and the proposed dates		☐
16.	Application fees		☐
17.	Copy of written agreement with 1 or more acute care hospital(s) to provide clinical experience, or		☐
18.	Copy of written agreement with 1 or more operational ambulance provider(s) to provide field experience		☐

EMT 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

EMT TRAINING PROGRAM
STUDENT PERFORMANCE DOCUMENTATION
CLINICAL TIME VERIFICATION/CLINICAL SKILLS SHEET/HOSPITAL

MANDATORY SKILLS: The following skills must be performed during each clinical rotation for successful completion of clinical internship. Record with evaluators initials after completion.

☐ ***Check here if this patient contact was through use of High-Fidelity Simulation.***

BLOOD PRESSURE			
Adult	1	2	3
Child	1	2	
PULSE			
Radial	1	2	3
Carotid	1	2	
Dorsal Pedal	1	2	
Posterior Tibia	1	2	
Apical	1	2	
RESPIRATIONS			
Adult	1	2	3
Child	1	2	
LUNG SOUNDS	1	2	
TEMPERATURE			
Oral	1	2	
Axillary	1	2	
Rectal	1	2	
PUPIL RESPONSE	1	2	3

DESIRABLE SKILLS: The following skills are desirable experiences. Record evaluators initials in appropriate box.

	PERFORMED	**OBSERVED**	**NOT DONE**
Application of Oxygen Mask/Nasal Cannula			
Suctioning			
Ventilation of Patient With BVM			
Perform CPR			
Clean and Dress Wound			
Control Bleeding			
Total Body Check			
Obtain Patient History			
Burn Treatment			
Assist With Trauma Patient			
Assist With Violent Patient			
Moving Patients			

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: _____ ☐ ALS ☐ BLS

Address: _____

County: _____

Liaison: _____

Title: _____ Phone: _____

E-mail: _____

Name: _____ ☐ ALS ☐ BLS

Address: _____

County: _____

Liaison: _____

Title: _____ Phone: _____

E-mail: _____

EMT TRAINING PROGRAM
NOTIFICATION OF PROPOSED COURSE

PROVIDER NAME: _____

Address: _____

Location of Instruction: _____

County: _____

Address (if different): _____

INSTRUCTOR NAME: _____ Phone: _____

E-mail: _____

COURSES SCHEDULED:

☐ Basic Fee $ _____

☐ Refresher Fee $ _____

☐ Written & Skills Fee $ _____

☐ Challenge Fee $ _____

_____ _____

Course Starting Date Course Completion Date

_____ _____

Date of Written Certifying Exam Date of Skills Certifying Exam

Submitted by: _____

Name (Program Director)

_____ _____

Signature Date

NOTE: This notification should be submitted to ICEMA not less than 30 days before the start of the course. The Program 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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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)

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 Responder (EMR)

New: _____
Renewal: _____
Update: _____

Emergency Medical Technician-Paramedic (EMT-P)

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

Emergency Medical Technician (EMT)

New: _____
Renewal: _____
Update: _____

Mobile Intensive Care Nurse (MICN)

New: _____
Renewal: _____
Update: _____

Advanced Emergency Medical Technician (AEMT)

New: _____
Renewal: _____
Update: _____

Continuing Education

All CE Courses (not included above): _____