INLAND COUNTIES
EMERGENCY MEDICAL AGENCY
Serving
San Bernardino, Inyo & Mono Counties

APPROVAL PACKET

for

Mobile Intensive Care Nurse (MICN) Training Program

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

Mobile Intensive Care Nurse (MICN) 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 Mobile Intensive Care Nurse (MICN) Training Program.

REQUIREMENTS FOR MICN TRAINING PROGRAM APPROVAL:

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

MICN TRAINING PROGRAM

I. PROCEDURES

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

CHECKLIST FOR MICN 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 MICN training program approval		☐
3.	Statement of eligibility for training program approval		☐
4.	Written request to ICEMA for MICN training program approval		☐
5.	Samples of written and skills examinations used for periodic testing		☐
6.	Final written examination		☐
7.	Name and qualifications of the program director, program clinical coordinator, and principal instructor(s)		☐
8.	Evidence the course/program director has completed 40 hours in teaching methodology or equivalent per COR, Title 22, Division 9, Chapter 2, §100070		☐
9.	Location where courses are to be offered and the proposed dates		☐
10.	Application fees		☐

Application for MICN 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

MICN 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: ____________________

MICN 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 $ ____________________

____________________ ____________________
Course Starting Date Course Completion Date

____________________ ____________________

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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MOBILE INTENSIVE CARE NURSE COURSE COMPLETION RECORD

TYPE OF COURSE: ☐ Basic

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 MICN. I have informed the class of ICEMA's Online Credentialing System to apply for MICN - Base Hospital Authorization, and have distributed the current policy Reference #1040 - MICN Authorization to each student.

______________________ ______________
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 MICN course and were issued a tamper resistant MICN 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.

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): ______________