



Paramedic Infrequent or Critical Skills Verification

Skills verification shall be verified by direct observation of an actual or simulated patient contact, within the individual's licensure cycle.

Provider Agency: _____ Calendar Year: _____

Paramedics Name: _____ License Number: _____

Skills Verification *Minimum Standards*

1. Needle Chest Decompression

1.1. Date of Verification: _____

1.2. Evaluator(s) Name and License Number: _____ # _____

2. Pediatric Airway Management

2.1. Date of Verification: _____

2.2. Evaluator(s) Name and License Number: _____ # _____

3. Adult Airway Management

3.1. Date of Verification: _____

3.2. Evaluator(s) Name and License Number: _____ # _____

4. Hemorrhage Control

4.1. Date of Verification: _____

4.2. Evaluator(s) Name and License Number: _____ # _____

5. Transcutaneous Cardiac Pacing and Cardioversion (Adult and Pediatrics)

5.1. Date of Verification: _____

5.2. Evaluator(s) Name and License Number: _____ # _____

6. External Jugular (EJ) IV Cannulation

6.1. Date of Verification: _____

6.2. Evaluator(s) Name and License Number: _____ # _____

7. Medication Administration: Nerve Agent Exposure, Ketamine, Epinephrine Dilution.

7.1. Date of Verification: _____

Evaluator(s) Name and License Number: _____

8. Emergency Childbirth

8.1. Date of Verification: _____

8.2. Evaluator(s) Name and License Number: _____ # _____

9. Interosseous Placement and Infusion (in order of preference)

Vascular Access:

Adult:

☐ Proximal Humerus

☐ Proximal Tibia

☐ Distal Tibia

9.1. Date of Verification: _____

9.2. Evaluator(s) Name and License Number: _____ # _____

Pediatric:

☐ Proximal Tibia

☐ Distal Tibia

☐ Distal Femur

9.3. Date of Verification: _____

9.4. Evaluator(s) Name and License Number: _____ # _____

I certify all information on this form, to the best of my knowledge, is true and correct.

Signature of EMS Coordinator/EMS Training Coordinator: _____

Name: _____

Date: _____

EMS Approved Training Agency: _____