SACRAMENTO COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF EMERGENCY MEDICAL SERVICES
EMT-I TRAINING PROGRAM
2E. HOSPITAL CLINICAL COORDINATOR

(If same as Program Director, complete only name, last section of form and sign.)

Name:
Address:
Phone: ( )
Occupation:
Present Employer:
Professional and/or Academic Degree(s) currently held:
Professional License Number(s) (must be current and State of California):
Expires:
Expires:
Expires:
Expires:

Emergency Care - Related Experience (showing two applicable years in the past five):			
Position	Responsibilities	Institution	Dates
(attach resume)			
1.			
2.			
3.			

Emergency Care - Related Education (within the past two years):			
Course Title	School	Course Length	Completion Date
1.			
2.			
3.			

I will / will not (circle one) be teaching portions of the training program. If yes, list Course Content you will teach, by subject.
Signature/Date: _____ Program Director

02/07/06