

**WREMAC PRECEPTOR APPLICATION**

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

EMT Certification #: \_\_\_\_\_ Level of Care: \_\_\_\_\_

Total # of yrs certified: \_\_\_\_\_ Total # of yrs at current level: \_\_\_\_\_

Current Instructor Credentials (CLI, CIC, CPR, ITLS, etc...): \_\_\_\_\_

All Current Agency Affiliations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Preceptor Course Taken: \_\_\_\_\_  
(Date)

Given by: \_\_\_\_\_

I affirm that as a WREMAC Medical Director \_\_\_\_\_ meets the requirements per description and qualification to be a WREMAC preceptor.

Medical Director:

Name:	Signature:	Title:	Date:
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Registered with Program Agency: \_\_\_\_\_  
(Date)

Program Agency Notified WREMAC: \_\_\_\_\_  
(Date)