



# AEMT

## Mandatory Annual Skills Evaluation Form

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

Certification #: \_\_\_\_\_ CPR Expiration: \_\_\_\_\_

Certification Expiration: \_\_\_\_\_ TLS Expiration: \_\_\_\_\_

Primary EMS Agency: \_\_\_\_\_

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

			Circle Method Used to Demonstrate Skill (See options below)		
	Date: _____	Evaluator: _____	1	2	3
AED	Date: _____	Evaluator: _____	1	2	3
Epi-Pen	Date: _____	Evaluator: _____	1	2	3
Nebulized Albuterol	Date: _____	Evaluator: _____	1	2	3
Blood Glucose Monitoring	Date: _____	Evaluator: _____	1	2	3
BLS EKG Monitoring*	Date: _____	Evaluator: _____	1	2	3
IV w/Trap (Adult and Ped)	Date: _____	Evaluator: _____	1	2	3
IO (adult & pediatric) *	Date: _____	Evaluator: _____	1	2	3
EJ Cannulation *	Date: _____	Evaluator: _____	1	2	3
ET Intubation (adult)	Date: _____	Evaluator: _____	1	2	3
Rescue Airways (Kings, etc)	Date: _____	Evaluator: _____	1	2	3
CPAP*	Date: _____	Evaluator: _____	1	2	3
IM Syringe Epi*	Date: _____	Evaluator: _____	1	2	3
IV Bolus Medication	Date: _____	Evaluator: _____	1	2	3
Subcutaneous/IM injection	Date: _____	Evaluator: _____	1	2	3

**\* Demonstrated only if agency is credentialed to use the skill**

Annual Skills Verification (Evaluator): \_\_\_\_\_

Print Signature

Provider Signature: \_\_\_\_\_

Medical Director Name: \_\_\_\_\_

Skill competency shall be demonstrated to the medical director (or his designee), as follows:

1. Demonstrate the skill
2. Verified the skill from QA/QI
3. Attending an approved Med Dir training

**\*\*A copy of this summary must be maintained in each providers agency file.\*\***