

## EMT - CC

## **Mandatory Annual Skills Evaluation Form**

Name:			Date:			
Certification #:			CPR Expiration:			
Certification Expiration:						
Primary EMS Agency:			PLS Expiration:			
Email Address:			ACLS Expiration:			
				Circle M Demo	onstrat	Used to e Skill below)
Nebulized Medication	Date:	Evaluator:		_ 1	2	3
Blood Glucose Monitoring	Date:	Evaluator:		_ 1	2	3
IV w/Trap (adult & 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
Manual Defibrillation	Date:	Evaluator:		_ 1	2	3
Lead II cardiac Monitoring	Date:	Evaluator:		_ 1	2	3
12-lead monitoring	Date:	Evaluator:		_ 1	2	3
Synchronized cardioversion	Date:	Evaluator:		_ 1	2	3
External Pacing	Date:	Evaluator:		_ 1	2	3
Needle Thoracostomy	Date:	Evaluator:		_ 1	2	3
IV Bolus Medication	Date:	Evaluator:		_ 1	2	3
Subcutaneous/IM injection	Date:	Evaluator:		1	2	3
* Demonstrated only if agenc	y is credentialed to use t	he skill				
Annual Skills Verification (Eval						
Duranisla a Circuratura	Print		Signature			
Provider Signature:						
Medical Director Name:						
<del></del>						
Skill competency shall be dem	onstrated to the medical	director (or his design	nee), as follows:			

**1.** Demonstrate the skill

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

 $<sup>{\</sup>bf **A \, copy \, of \, this \, summary \, must \, be \, maintained \, in \, each \, providers \, agency \, file. \, **}$