Paramedic

Mandatory Annual Skills Evaluation Form

Name: ______________________ Date: ______________

Certification #: ______________________ CPR Expiration: ______________

Certification Expiration: ______________________ TLS Expiration: ______________

Primary EMS Agency: ______________________ PLS Expiration: ______________

Email Address: ______________________ ACLS Expiration: ______________

Skill	Date	Evaluator	Circle Method Used to Demonstrate Skill (See options 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**
ET Intubation (pediatric)	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**
Surgical Cricothyrotomy*	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.****

REVISED MARCH 2018