Is this course open? **Yes** ☐ **No** ☐

T-1B
INITIAL EMT-B

FOR OFFICE USE ONLY

Primary EMS-I: _____
Address: _____
City/Zip: _____
Telephone: W_____ H_____
E-mail address: _____
Sponsoring Agency: _____
Location: _____
Address: _____
City/Zip: _____
Building/Room #: _____

Course Dates:
From: _____ To: _____
Meeting Times:
Mon: _____ Fri: _____
Tues: _____ Sat: _____
Wed: _____ Sun: _____
Thu: _____
Total # of Students:

Program Information

Medical Director: _____ Hospital Affiliation: _____
Print Name

Signature: _____

Clinical Training/
Observation Sites: _____ Contact: _____ Phone: _____

Program must have signed agreement with all clinical training/observation sites. **Attach copies of agreements to this application.**

Faculty Name: _____ Title: _____

Attach names of additional faculty at the end of this application

I certify that the information contained on this page is a true and accurate account of the course curriculum. _____

EMSI Signature

Lesson Titles & Minimum Hrs.		Hrs	Dates & Times	Instructor(s)
CPR for the Professional Rescuer	(9)			
MODULE 1: PREPARATORY				
Introduction to Emergency Care	(1.5)			
Well Being of the EMT-Basic	(1.5)			
Medical/Legal-Ethical Issues	(1.5)			
The Human Body	(2.5)			
Baseline Vital Signs/SAMPLE History	(2)			
Lifting & Moving Patients	(3)			
Evaluation/Review	(1)			
MODULE 2: AIRWAY				
Airway	(4)			
Practical Lab – Airway	(2)			
Evaluation/Review	(1)			
MODULE 3: PATIENT ASSESSMENT				
Scene Size-up	(0.5)			
Initial Assessment	(1)			
Focused History & Physical – Trauma	(4)			
Focused History & Physical – Medical	(2)			
Detailed Physical Exam	(1.5)			
Ongoing Assessment	(1)			
Communications	(1)			
Documentation	(1.5)			
Practical Lab – Patient Assessment	(8)			
Evaluation/Review	(1)			

I certify that the information contained on this page is a true and accurate account of the course curriculum. _____

EMSI Signature

Lesson Titles & Minimum Hrs.		Hrs	Dates & Times	Instructor(s)
MODULE 4 MEDICAL/BEHAVIORAL&OBGYN				
General Pharmacology	(1)			
Respiratory Emergencies	(3)			
Cardiovascular Emergencies	(7)			
Diabetes/Altered Mental Status	(2)			
Allergies	(2)			
Poisoning/Overdose	(2)			
Environmental Emergencies	(2)			
Behavioral Emergencies	(2)			
Obstetrics/Gynecology	(2)			
Practical Lab – Medical/Behavioral/OBGYN	(8)			
Evaluation/Review	(1)			
MODULE 5: TRAUMA				
Bleeding and Shock	(2)			
Soft Tissue Injuries	(2)			
Musculoskeletal Care	(4)			
Injuries to the Head & Spine	(4)			
Practical Lab – Trauma	(6)			
Evaluation/Review	(1)			
MODULE 6: INFANTS & CHILDREN				
Infants & Children	(3)			
Practical Lab – Infants & Children	(3)			
Evaluation/Review	(1)			

Lesson Titles & Minimum Hrs.		Hrs	Dates & Times	Instructor(s)
MODULE 7: OPERATIONS				
Ambulance Operations	(1)			
Gaining Access	(1)			
Overviews	(2)			
Evaluation/Review	(1)			
Clinical Training/Observation	(10)			
Elective:				
Elective:				
Elective:				
Elective:				
COURSE FINALS				
Final Written Evaluation	(2)			
Final Practical Evaluation	(5)			
TOTAL HOURS	*Minimum of 130*			

I certify that I, as the Primary EMS- Instructor, have completed and submitted all 5 pages of this "T-1B" EMT-Basic Application to Conduct Training, and that this represents a true and accurate record of the topics to be covered during the EMT-Basic Program as well as the dates, times, and instructor(s) for each lesson. I certify that this course meets the most recently published AHA Guidelines , National Standard Training Curricula, as approved by the United States Department of Transportation, National Highway Safety Traffic Administration, and will adhere in form and content, to all applicable Connecticut Office of Emergency Medical Services Policies.

Primary EMS-Instructor Signature	Name (Printed)	EMS-I Certification #	Exp. Date

T-1B Checklist and Verification List

Use the checklist below to verify that all portions of this application have been completed and that all required adjunct documents have been included with your application.

- ☐ Verify that all course information on the top of page 1 has been entered correctly
- ☐ Verify that Date/Time scheduled and instructor information is completed for each topic on page 2 through 4
- ☐ Verify that the Primary EMS-Instructor has signed on pages 2 through 5, and included current EMS-I number
- ☐ Attach names and titles of additional faculty/instructors not included on page 1
- ☐ Mail this completed application to: State of Connecticut, Department of Public Health, 410 Capitol Ave., MS#12EMS, Hartford, CT 06134

FOR OFFICE USE ONLY – DO NOT WRITE IN AREA BELOW

Place Date Stamp in Box Signature	Place Date Stamp in Box Signature	Place Date Stamp in Box Signature	Place Date Stamp in Box Signature	Place Date Stamp in Box Signature
Date Received	Reviewed By	Returned/Denied	Received Corrected	Approved