T-1R

EMT REFRESHER

FOR OFFICE USE ONLY

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

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

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: _____

Faculty Name: _____ Title: _____

Attach names of additional faculty at the end of this application

Note: Accommodations can be made for individuals who have already received CPR training and/or regional training and authorization to function at the AED level and/or EPI level. Should an individual be excused from a portion of the AED and/or EPI lessons due to other training and authorizations, it is imperative that the instructor check and verify all pertinent regional records for confirmation.

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

EMSI Signature

Lesson Titles & Recommended Hrs.	Hrs	Dates & Times	Instructor(s)
Required: CPR/Defibrillation (4-6)			
Required: Safety/Well Being (0.5)			
Required: BSI/ Infection Control (1)			
Required: Medical/Legal Issues (0.5)			
Required: Airway, Adjuncts & Oxygen (2-4)			
Required: Patient Assessment (3-6)			
Medical			
Trauma			
Required: Documentation (1)			
Required: Medical/Behavioral (3-5)			
Emergencies (*with interventions)*			
Required: Trauma (4-6)			
Bleeding/Shock/Soft Tissue			
Musculoskeletal/Head & Spine			
Required: Obstetrics & Gynecology (1-2)			
Required: Infants & Children (2-3)			
Elective: Hazmat Awareness (2-3)			
Elective: Mass Casualty			
Elective: MAST			
Elective:			
Elective:			
Testing			
Final Written Exam (2 Required)			
Final Practical Exam (1)			
Total Hours *Minimum of 25*			

I certify that I, as the Primary EMS- Instructor, have completed and submitted all 3 pages of this "T-1R" EMT-Refresher Application to Conduct Training, and that this represents a true and accurate record of the topics to be covered during the EMT-Refresher 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-1R Checklist and Verification Sheet

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
- ☐ Verify that the Primary EMS-Instructor has signed on pages 2 and 3, and included current EMS-I number
- ☐ Attach names and titles of **additional** faculty/instructors not included on page 1
- ☐ Mail completed application to: State of Connecticut, Department of Public Health, 410 Capitol Ave., MS#12EMS, Hartford, CT 06134

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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