STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Emergency Medical Services

Application to Conduct Paramedic Training

OEMS Approval # _____

I.) Program Information

(*please type or print clearly*)

Program Coordinator:_____

Address:_____

City/Zip: _____

Telephone: (day)_____**(eve.)** _____

Medical Director:_____

Sponsoring Agency:_____

Course Location:_____

Address:_____

City/Zip:_____

Class Location: Building/Room#:_____

Is this course open to the public? **yes [ ]** **no [ ]**

Is this course currently accredited by the JRC? **yes [ ]** **no [ ]**

Course Dates: From (date): _____**To (date):**_____

Meeting Days & Times:

Mon. [ ]_____
Tue. [ ]_____
Wed. [ ]_____
Thur. [ ]_____
Fri. [ ]_____
Sat. [ ]_____
Sun. [ ]_____

Phone:
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # _____
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

II.) Program Coordinator Statement

I certify that I, the Course Program Coordinator, have completed and submitted all pages of this Application to Conduct Paramedic Training, and that this application, and all attachments, represent a true and accurate record of the training program to be conducted. I certify and attest that this course meets, both in form and content, the most recent edition of the U.S. Department of Transportation, National Highway Traffic Safety Administration EMT-Paramedic, National Standard Curriculum. I further attest that the conduct of the course described herein will adhere in form and content to all applicable Connecticut Department of Public Health Regulations and Connecticut General Statutes.

As the Program Coordinator, I will routinely review each student's performance to assure adequate progress toward completion of the program, and will attest that each graduating student has achieved the required level of competence as delineated in the D.O.T. curriculum, prior to graduation.

_____ _____

Program Coordinator (signature) **Date**

_____

Program Coordinator Name (printed)

III.) Physician Medical Director Statement

I certify that I, the Paramedic Program Medical Director, am currently and actively affiliated with the Sponsor Hospital for the Paramedic Training Program. I am a sponsor hospital emergency department physician with experience and current knowledge of emergency care of acutely ill and traumatized patients. I am also knowledgeable about the EMT-Paramedic educational programs, paramedic scope of practice, and the provision of base station on-line medical direction.

As part of my duties as Program Medical Director, I certify that I will review and approve the educational content of the program curriculum and the quality of the medical instruction and supervision delivered by the faculty. I will routinely review each student's performance to assure adequate progress toward completion of the program, and will attest that each graduating student has achieved the required level of competence as delineated in the D.O.T. curriculum, prior to graduation.

_____ _____

Program Medical Director (signature) **Date**

_____

Program Medical Director Name (printed)

_____

Specialty Area

_____

Telephone Number

IV.) Clinical Site Information

List all clinical sites, including field ridership/preceptor sites at which students will perform clinical skills: (*you must attach (behind this page) copies of current, dated, signed agreements with each of the below listed sites*)

Clinical Site	Contact Person	Phone Number

Copy and attach additional pages if needed

V.) Program Syllabus

Please attach (behind this page) a syllabus (class outline) that includes the following information:

1.) Date, time and location of each class

2.) Topic/subject for each class

3.) Tentative faculty assignment for each class

Note: *The Office of Emergency Medical Services will not review the attached syllabus for adherence to the D.O.T. Curriculum. It is incumbent upon the Course Coordinator and Physician Medical Director to ensure that the standards of the DOT curriculum are met.*

OEMS may however, do a random audit of your lesson plans, attendance rosters, clinical competency forms, or any other course-related documentation, for purposes of compliance, quality assurance or investigation.

VI.) Required Attachments
Checklist

Your application will not be considered for approval unless all of the required attachments are included. Incomplete applications will be returned to the applicant.

[ ] Curriculum Vitae of Program Medical Director

[ ] Curriculum Vitae of Program Coordinator

[ ] Signed agreements with all Clinical Rotation Sites and Field Preceptor services

[ ] Certificate(s) of Insurance which demonstrate that Medical/Professional Liability Insurance is in force for all students and faculty

[ ] List of all faculty/Instructors who are affiliated with the course to include title and credentials

[ ] Course Syllabus

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