TN Department of Health

EMERGENCY MEDICAL RESPONDER PRACTICAL SKILLS VERIFICATION

Student Name: _____ **Last 4 digits of SSN:** _____

Training Agency: _____ **Class Number:** _____

SKILL	DATE (mm/dd/yyyy)	SATISFACTORY (Y/N)	INSTRUCTOR INITIALS
PATIENT ASSESSMENT			
Medical			
Trauma			
Vital Signs (B/P, pulse, respirations)			
OXYGEN ADMINISTRATION			
Oxygen Tank Set Up			
Nasal Cannula			
Non-Rebreather Mask			
AIRWAY ADJUNCTS/SUCTION			
Oral Airways			
Bag-Valve-Mask			
Mouth-to-Barrier			
Mouth-to-mask			
Oral Suctioning			
BANDAGING			
Eye Irrigation and Bandage			
Head Bandage			
Amputation			
SPLINTING			
Sling And Swathe			
Cervical Collar /Manual Stabilization			
Radius/Ulna Board			
Tibia/Fibula Board			
HEMORRHAGE CONTROL			
Direct Pressure			
Tourniquet			
Wound Packing			
MEDICATIONS/ROUTE			
Intramuscular- Auto Injector			
Intranasal- Unit Dosed, Premeasured			
CARDIAC ARREST MANAGEMENT			
Defibrillation-Automated/Semi-Automated			
CPR Exp Date_____			

Note: This form is based on EMR skills as listed in the National EMS Scope of Practice Model. Other EMS Board Approved Clinical Practices require Medical Director authorization and appropriate initial and continuing skill credentialing.

This individual has demonstrated knowledge and skill competencies in the above listed procedures and has met all course attendance and completion requirements.

_____ _____ _____

Instructor Printed Name **Date** **Instructor Signature**

I acknowledge that I have performed and practiced each of the skills listed above.

_____ _____ _____

Students Printed Name **Date** **Student Signature**