

PARAMEDIC TRAINING PROGRAM APPLICATION (# 4602)

Note: Paramedic Training Program requirements can be found in the California Code of Regulations, Title 22, Division 9, Chapter 4, Article 3, § 100148 – 100161. The Paramedic Training Program Application Packet that must be submitted with this application can be requested from the EMS office.

Initial Application Renewal

PARAMEDIC TRAINING PROGRAM NAME: _____

PROVIDER LOCATION (County of primary headquarters): _____

MAILING ADDRESS: _____
Street City Zip

PHONE NUMBER: (____) _____ **FAX NUMBER:**(____) _____

PROGRAM MEDICAL DIRECTOR: _____

COURSE DIRECTOR: _____

COURSE DIRECTOR E-MAIL: _____

ELIGIBILITY:

- Accredited universities and colleges including junior and community colleges, school districts, and private post-secondary schools.
- Medical training units of a branch of the Armed Forces or Coast Guard of the United States
- Licensed general acute care hospitals
- Agencies of government

STUDENT ELIGIBILITY: Employees only Open to the public

CONTINUING EDUCATION PROVIDER: Training Programs wishing approval as a Continuing Education Provider should complete Continuing Education Provider Application (Policy 4600). CE provider requirements can be found in Title 22, Division 9, Chapter 11.

LOCAL EMS AGENCY AUTHORITY: All training programs located in Alameda County, regardless of where headquartered or approved, are required to submit on an on-going basis, up-to-date training program information, including program director, clinicals coordinators, principle instructors, class schedules, and rosters; and may be audited for compliance with regulations. Title 22, Division 9, Chapter 2, Article 1, § 100057 – 58, Article 3, § 100066, 100071 & 100077, Article 4, § 100082.

I certify that I have read and understand the requirements in Title 22, Chapter 4, Article 3 to be an approved Paramedic Training Program, and will comply with the requirements as described. I certify that all information on this application, to the best of my knowledge, is true and correct. I understand that failure to comply with the requirements in Title 22 may result in revocation of this program approval.

Course Director Signature: _____ **Date:** _____

For Alameda County EMS Use Only

| Application Received | Application Incomplete - Returned | Application Approved | Expiration Date | Reviewed By |
|----------------------|-----------------------------------|----------------------|-----------------|-------------|
| / / | / / | / / | / / | |

Comments:

PARAMEDIC TRAINING PROGRAM

Application Check-list

The following material must be submitted with your initial or renewal application form (Policy 4602). Failure to provide the required material within the required timeframe will delay your approval or re-approval as a Paramedic Training Program.

| Material to be submitted: | Initial Program | Program Renewal | EMS agency use |
|--|------------------------|------------------------|-----------------------|
| Application form (policy #4602) | | | |
| Course Director resume and qualifications form | | | |
| Program Medical Director resume and qualifications form | | | |
| Principal Instructor qualifications form (one for each principal instructor) | | | |
| Program Clinical Coordinator resume and qualifications form | | | |
| Teaching Assistants Form | | | |
| A statement identifying which Paramedic curriculum is used (equivalent to the U.S. DOT EMT-P National Standard Curriculum HS 808 862 March 1999) | | | |
| A statement attesting to the number of course hours (broken down by didactic and skills, and hospital clinical and field internships) | | | |
| An outline of course objectives | | | |
| Performance objectives for each skill | | | |
| A statement identifying provisions for and hospitals used for clinicals | | | |
| Written agreements with hospitals for student clinicals | | | |
| Student evaluation criteria and standardized forms for evaluating students and monitoring of preceptors in the hospital setting | | | |
| A statement identifying provisions for and ALS providers used for field internships | | | |
| Written agreements with ALS providers for student field internships | | | |
| Student evaluation criteria and standardized forms for evaluating students and monitoring of preceptors in a field internship setting | | | |
| Sample tamper resistant course completion certificate | | | |
| Samples of skills examinations for periodic testing | | | |
| Samples copy of a final written examination | | | |
| Statements describing the facilities and equipment, and provisions for examination security and student record keeping | | | |
| The location of courses and proposed start dates | | | |

| | | | |
|--|--|--|--|
| A statement of the anticipated submission date of materials to CoAEMSP for CAAHEP accreditation | | | |
| Copies of the pre-enrollment letter provided to applicants explaining the CAAHEP accreditation process | | | |
| A calendar of courses given in the past year showing dates of courses and numbers of students | | | |

PARAMEDIC TRAINING PROGRAM

COURSE DIRECTOR

Name: _____

Agency: _____

Address: _____

Street

City

Zip

Telephone number: _____

Main

Fax

Cell

e-mail address: _____

Qualifications - Each Paramedic Training Program shall have an approved Course Director who shall be qualified:

- By education and experience in methods, materials, and evaluation of instruction
- And shall have a minimum of one year experience in an administrative or management level position
- And have a minimum of three years academic or clinical experience in prehospital care education within the last five years.

Check one and submit documentation verifying one of the following:

- Physician
- Registered nurse with a baccalaureate degree
- Paramedic with a baccalaureate degree
- An individual who holds a baccalaureate degree in a related health field or in education

Experience: Submit a resume including licenses/certificates, job and/or clinical experience and demonstration of your education and experience in methods, materials, and evaluation of instruction.

I certify that I have read and understand the requirements in Title 22, Chapter 4, Article 3, § 100149 regarding the duties of the Course Director and will comply with the requirements as described. I certify that all information on this application, to the best of my knowledge, is true and correct.

Signature_____
Date

PARAMEDIC TRAINING PROGRAM

PROGRAM MEDICAL DIRECTOR

Name: _____

Agency: _____

Address: _____
Street
City
ZipTelephone number: _____
Main
Fax
Cell

e-mail address: _____

Qualifications - Each Paramedic Training Program shall have an approved Program Medical Director, licensed in California, who has two years experience in prehospital care in the last five years and who is qualified by education and experience in methods of instruction.

Experience: Submit a resume including licenses/certificates, job and/or medical experience and demonstration of your education and experience in methods, materials, and evaluation of instruction.

I certify that I have read and understand the requirements in Title 22, Chapter 4, Article 3, § Section 100149 regarding the duties of the Program Medical Director and will comply with the requirements as described. I certify that all information on this application, to the best of my knowledge, is true and correct.

Signature_____
Date

PARAMEDIC TRAINING PROGRAM

PRINCIPAL INSTRUCTOR(S)

Name: _____

Agency: _____

Address: _____
Street
City
ZipTelephone number: _____
Main
Fax
Cell

e-mail address: _____

Qualifications – Principle Instructors must be approved by the Program Director and Medical Director and shall:

- Be qualified by education and experience in methods, materials, and evaluation of instruction
- Have two years experience in ALS prehospital care and be knowledgeable in the course content of the U.S. DOT EMT-P National Standard Curriculum HS 808 862 March 1999)
- Have six years experience in an allied health field or related technology and an associate degree
- Or have two years experience in an allied health field or related technology and a baccalaureate degree

Check one and submit documentation verifying one of the following:

- Physician
- Registered nurse
- Physician assistant
- Paramedic – License # _____

Experience: Submit a resume including licenses/certificates, job and/or clinical experience and demonstration of your education and experience in methods, materials, and evaluation of instruction.

I certify that I have read and understand the requirements in Title 22, Chapter 4, Article 3, § 100149 regarding the duties of the Principal Instructor, and will comply with the requirements as described. I certify that all information on this application, to the best of my knowledge, is true and correct.

Signature_____
Date

PARAMEDIC TRAINING PROGRAM

HOSPITAL CLINICAL PRECEPTOR

Name: _____

Agency: _____

Address: _____
Street
City
ZipTelephone number: _____
Main
Fax
Cell

e-mail address: _____

Qualifications - Each Paramedic Training Program shall have an approved Hospital Clinical Preceptor who shall be qualified by education and experience in methods, materials, and evaluation of instruction. Check one and submit documentation verifying one of the following:

- Physician
- Registered nurse
- Physician assistant

Experience: Submit a resume including licenses/certificates, job and/or clinical experience documentation in emergency medical care for the last two (2) years.

I certify that I have read and understand the requirements in Title 22, Chapter 4, Article 3, § 100149 regarding the duties of the Hospital Clinical Preceptor, and will comply with the requirements as described. I certify that all information on this application, to the best of my knowledge, is true and correct.

Signature_____
Date

PARAMEDIC TRAINING PROGRAM

TEACHING ASSISTANTS

Name: _____

Employer: _____

Qualifications: EMT-P / RN

License /Certificate Number: _____

Name: _____

Employer: _____

Qualifications: EMT-P / RN

License /Certificate Number: _____

Name: _____

Employer: _____

Qualifications: EMT-P / RN

License /Certificate Number: _____

Name: _____

Employer: _____

Qualifications: EMT-P / RN

License /Certificate Number: _____

Name: _____

Employer: _____

Qualifications: EMT-P / RN

License /Certificate Number: _____

Name: _____

Employer: _____

Qualifications: EMT-P / RN

License /Certificate Number: _____