Terminal Competency Form

(Check one)

❑ Emergency Medical Technician - Responder
❑ Emergency Medical Technician
❑ Advanced Emergency Medical Technician

We hereby attest that the candidate listed below has successfully completed all the Terminal Competencies required for graduation from an Initial Education program as a minimally competent, entry-level, provider and as such is eligible for National Certification written and practical examination in accordance with our published policies and procedures.

Name of Graduate: _______________________________________________________

D.O.B. ________________

PROGRAM REQUIREMENTS successfully and fully completed on: ________________

Written Examinations (list those courses/sections that require final exam or final grade)

<table>
<thead>
<tr>
<th>Section</th>
<th>Grade</th>
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</tr>
</thead>
<tbody>
<tr>
<td>(Ex: Trauma)</td>
<td>(90)</td>
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<td></td>
<td></td>
<td>Clinical*</td>
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<td>Field Internship</td>
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<td>Team Leads**</td>
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</table>

*Optional for EMT/AEMT
**AEMT Level only

❑ Practical Skills Sheets (all program required skills sheets)
❑ Clinical Tracking Records (attended all required areas, completed required skill repetitions, etc.)
❑ Field Internship Tracking Records (number of team leads, achieved objectives, etc.)
❑ Affective learning domain evaluations
❑ Student Counseling Form (s), as applicable

CARD COURSE CERTIFICATIONS Issue date (if applicable, prior to graduation)

<table>
<thead>
<tr>
<th>BLS CPR*</th>
<th>ACLS</th>
<th>ICS 100*</th>
</tr>
</thead>
<tbody>
<tr>
<td>PALS/EPC</td>
<td>GEMS</td>
<td>ICS 700*</td>
</tr>
<tr>
<td>ITLS/PHTLS</td>
<td>TIMS*</td>
<td>Other:</td>
</tr>
</tbody>
</table>

*are required courses for successful completion of an initial education course.

Name of Program: _______________________________________________________

Course Approval #: ____________________________________________________

Student (signature & date) ________________________________________________

Program Director (signature & date) _______________________________________

Medical Director* (signature & date) _______________________________________

*(recommended)