



GEORGIA OFFICE OF EMERGENCY MEDICAL SERVICES AND TRAUMA

Form T-04-A

EMS EDUCATION PROGRAM APPLICATION

FOR DEPARTMENT USE ONLY

DPH/Regional Approval Number: _____ Date Received from Revision: _____
Date Received-Regional EMS Office: _____ Date Approved by Regional EMS Office: _____
Date Returned for Revision: _____ Date Facility Notified by EMS Regional Office: _____

COURSE APPLICATION FOR PROGRAM

EMERGENCY FIRST RESPONDER EMT ADVANCED EMT PARAMEDIC

Sponsoring Agency

Sponsoring Agency Name _____
Sponsoring Agency's Primary Contact Name _____
Phone Number _____ Email Address _____

Program Information

Program Name _____ Program Code _____
1st Line Mailing Address _____
2nd Line Mailing Address _____
City _____ State _____ Zip Code _____

Program Director

Program Director's Name _____ Phone Number _____
1st Line Mailing Address _____
2nd Line Mailing Address _____
City _____ State _____ Zip Code _____
Email Address _____

Primary Instructor

Program Instructor's Name _____ License Number _____
1st Line Mailing Address _____
2nd Line Mailing Address _____
City _____ State _____ Zip Code _____
Email address _____ Phone Number _____

Medical Director

Program Director's Name _____ Phone Number _____

1st Line Mailing Address _____

2nd Line Mailing Address _____

City _____ State _____ Zip Code _____

Email Address _____

Course Information

Course Location _____

Course Starting Date _____ Course Ending Date _____

Times Class Held _____ Classes to Meet (days of week) _____

Didactic Hours _____ Lab Hours _____

Clinical/Hospital Hours _____ Field Hours _____

Clinical Site 1 Information

Name of Clinical Site 1 _____

Clinical Site Type EMS Hospital Clinic Other - Explain _____

Primary Contact Name _____ Phone Number _____

Email Address _____

Clinical Site 2 Information

Name of Clinical Site 2 _____

Clinical Site Type EMS Hospital Clinic Other - Explain _____

Primary Contact Name _____ Phone Number _____

Email Address _____

Clinical Site 3 Information

Name of Clinical Site 3 _____

Clinical Site Type EMS Hospital Clinic Other - Explain _____

Primary Contact Name _____ Phone Number _____

Email Address _____

Clinical Site 4 Information

Name of Clinical Site 4 _____

Clinical Site Type EMS Hospital Clinic Other - Explain _____

Primary Contact Name _____ Phone Number _____

Email Address _____

Clinical Site 5 Information

Name of Clinical Site 5 _____

Clinical Site Type EMS Hospital Clinic Other - Explain _____

Primary Contact Name _____ Phone Number _____

Email Address _____

ADDITIONAL CLINICAL SITES MUST BE RECORDED ON ATTACHMENT A IF NECESSARY

Adjunct Instructors

Instructor Name 1 _____ License Level Number _____

Instructor Level Number _____

Instructor Name 2 _____ License Level Number _____

Instructor Level Number _____

Instructor Name 3 _____ License Level Number _____

Instructor Level Number _____

Instructor Name 4 _____ License Level Number _____

Instructor Level Number _____

Instructor Name 5 _____ License Level Number _____

Instructor Level Number _____

ADDITIONAL ADJUNCT INSTRUCTORS MUST BE RECORDED ON ATTACHMENT B IF NECESSARY

My signature affirms that the information contained herein is certified as true and correct to the best of my knowledge. Any changes to the application (schedule, instructors, contracts, etc.) after it is approved **MUST BE** submitted in writing and approved by the Regional EMS Program Director prior to the effective date(s) of the change. *(ALL SIGNATURES MUST BE ORIGINAL)*

SIGNATURES

Printed Name of Program Director _____

Signature of Program Director _____ Date _____

Printed Name of Medical Director _____

Signature of Medical Director _____ Date _____

REQUIRED DOCUMENTS

Supporting documents that must accompany this application:

1. Letter of Agreement from the Sponsoring Agency
2. Course Session Guide/Schedule (To include dates of classes)
3. Letter of Agreement from Course Medical Director

ADDITIONAL CLINICAL SITES - ATTACHMENT A

Clinical Site 6 Information

Name of Clinical Site 6 _____
Clinical Site Type EMS Hospital Clinic Other - Explain _____
Primary Contact Name _____ Phone Number _____
Email Address _____

Clinical Site 7 Information

Name of Clinical Site 7 _____
Clinical Site Type EMS Hospital Clinic Other - Explain _____
Primary Contact Name _____ Phone Number _____
Email Address _____

Clinical Site 8 Information

Name of Clinical Site 8 _____
Clinical Site Type EMS Hospital Clinic Other - Explain _____
Primary Contact Name _____ Phone Number _____
Email Address _____

Clinical Site 9 Information

Name of Clinical Site 9 _____
Clinical Site Type EMS Hospital Clinic Other - Explain _____
Primary Contact Name _____ Phone Number _____
Email Address _____

Clinical Site 10 Information

Name of Clinical Site 10 _____
Clinical Site Type EMS Hospital Clinic Other - Explain _____
Primary Contact Name _____ Phone Number _____
Email Address _____

Clinical Site 11 Information

Name of Clinical Site 11 _____
Clinical Site Type EMS Hospital Clinic Other - Explain _____
Primary Contact Name _____ Phone Number _____
Email Address _____

Adjunct Instructors

Instructor Name 6 _____ License Level Number _____

Instructor Level Number _____

Instructor Name 7 _____ License Level Number _____

Instructor Level Number _____

Instructor Name 8 _____ License Level Number _____

Instructor Level Number _____

Instructor Name 9 _____ License Level Number _____

Instructor Level Number _____

Instructor Name 10 _____ License Level Number _____

Instructor Level Number _____