

Materials to be Submitted	Check One		
	Enclosed	To Follow	For County Use Only
1. Documentation of Eligibility for Program Approval. 100149(i)			
2. Letter to Paramedic Approving Authority Requesting Approval.			
3. Check list for Paramedic Program Approval.			
4. Completed Application Form for Program Approval.			
5. Program Medical Director Qualification Form and Job Description. 100150(b)			
6. Program Course Director Qualification Form and Job Description. 10050(b)			
7. Program Principal Instructor(s) Qualification Form and Job Description. 100150(c)			
8. Teaching Assistant(s). 100150(E) Submit Names and Subjects Assigned to Each Teaching Assistant and Job Description.			
9. Field Preceptor(s). Submit Names, Qualifications and Job Description. 100150(f)			
10. Hospital Clinical Preceptor(s). Qualifications Form and Job Description. 100150(g)			
11. Copy of Written Agreements with (one or more) Base Hospital(s) to Provide Clinical Experience. 100152			
12. Provisions for Supervised Hospital Clinical Training Including Student Evaluation Criteria, and Copy of Standardized Forms for Evaluating EMT-P Students and Monitoring of Preceptors by the Training Program. 100152(e)			
13. Copy of Written Agreement with (one or more) Paramedic Service Provider(s) to Provide Field Experience. 1001534			
14. Provisions for Supervised Field Internship Including Student Evaluation Criteria, and Copy of Standardized Forms for Evaluating Paramedic Students and Monitoring of Preceptors by the Training Program. 100154			

Materials to be Submitted	Check One		
	Enclosed	To Follow	For County Use Only
15. Course Curriculum, including 100154: A. Course Outline B. Statement of Course Objectives C. At least 6 Sample Lesson Plans D. Performance Objectives for Each Skill E. At least 10 Samples of Written Questions Used in Periodic Testing F. Final Skills Exam			
16. Copy of Course Completion Record. 100162			
17. Copy of Liability Insurance on Students.			
18. Copy of Fee Schedule.			
19. Description of how Program Provides Adequate Facilities, Equipment, Examination Security and Student Recordkeeping. 100154			

**COUNTY OF SAN DIEGO DIVISION OF EMERGENCY MEDICAL SERVICES**

**APPLICATION FORM**

**PARAMEDIC TRAINING PROGRAM**

1. Name of Institution/Agency \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_

Zip Code \_\_\_\_\_

Contact Person \_\_\_\_\_

Telephone Number \_\_\_\_\_

Extension \_\_\_\_\_

Email Address: \_\_\_\_\_

2. Personnel:

Program Medical Director \_\_\_\_\_

Course Director \_\_\_\_\_

Principal Instructor(s) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Teaching Assistants \_\_\_\_\_

(Name & Subjects Assigned) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Clinical Preceptors:**

(Name and Base Hospital Affiliation)

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**Field Preceptors**

Name	Agency	Date of Original Paramedic Certification	Other Emergency Care Experience

3. Course Hours:

Total \_\_\_\_\_

Didactic and Skills Lab \_\_\_\_\_

Hospital Clinical Training \_\_\_\_\_

Field Internship \_\_\_\_\_

4. Texts \_\_\_\_\_

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COUNTY OF SAN DIEGO DIVISION OF EMERGENCY MEDICAL SERVICES  
PARAMEDIC TEACHING QUALIFICATIONS

Check One:

- Program Director
- Course Director
- Principal Instructor
- Clinical Preceptor

1. Name: \_\_\_\_\_

2. Occupation: \_\_\_\_\_

3. Professional or Academic Degrees Held:                      4. Professional License/Certification Number(s):

- |          |          |
|----------|----------|
| a. _____ | a. _____ |
| b. _____ | b. _____ |
| c. _____ | c. _____ |

5. California Teaching Credentials Held:

- |                |                        |
|----------------|------------------------|
| a. Type: _____ | Expiration Date: _____ |
| b. Type: _____ | Expiration Date: _____ |

6. Emergency Care-Related Education within the last 5 years:

	<u>Course Title</u>	<u>School</u>	<u>Course Length</u>	<u>Date Completed</u>
a.				
b.				
c.				

7. Emergency Care-Related Experience within the last 5 years:

	<u>Position</u>	<u>Duties</u>	<u>Organization</u>	<u>Dates</u>
a.				
b.				
c.				

Approvals:

\_\_\_\_\_  
Program Medical Director

\_\_\_\_\_  
Course Director

\_\_\_\_\_  
Date