OREGON HEALTH AUTHORITY
Emergency Medical Services and Trauma Systems
PO Box 14450
Portland OR 97293-0450
971-673-0526 Office; 971-673-0555 fax

APPLICATION TO CONDUCT COURSE

[ ] EMT [ ] AEMT [ ] EMT - I [ ] Paramedic

Please type/print and check all appropriate responses. Submit completed application and a copy of the course schedule to OHA/EMS at least 30 days prior to beginning the course.
IMPORTANT: The Course Director is to notify the Department immediately if the course is cancelled, or if the number of students or the course ending date has changed.
Course affiliation: [ ] Community College [ ] College/University [ ] Licensed Vocational School [ ] *Other (EMT – I only)*

Institution name: _____

Program administrator: _____ Telephone #: _____

E-mail: _____

Mailing address: _____
(Street or PO Box) (City) (State) (Zip)

Address where course will be conducted: _____

Course dates: Beginning: ___/___/___ Completion: ___/___/___ Projected # of Students: _____

Paramedic courses only: Completion Date Didactic: ___/___/___ Completion Date Clinicals: ___/___/___
ATTACH A COPY OF THE COURSE SCHEDULE
****
THE TEACHING INSTITUTION AGREES TO:

(1) Provide copies of all course director and guest lecturers specialty certificates to the Department when requested.
(2) Attach a copy of contracts to ensure that EMT and EMT-Paramedic students enrolled in an approved course have scheduled clinical and field internships to permit every student enrolled to complete these requirements within the timeframe of the approved course. Field preceptors must meet the qualifications as outlined in OAR 333-265-0000 (25).
(3) Assures the qualifications of Program Administrators, Course Directors, Assistant Instructors and guest lecturers as outlined in OAR 581-49-0010.
(4) Provide facilities to conduct the written and practical exam at no cost to the Department; and
(5) Notify eligible students of the date, time and location of the certification exam(s).
****
This is a formal request to conduct an EMT course. The teaching institution agrees to fully teach the Department-approved curriculum and fully understands that, failure to comply with the requirements listed in OAR 333-265-0010, furnishing any false information, or not following the approved curriculum shall constitute cause for the immediate suspension of this course or the possible denial of future course(s).

_____/_____/_____
Signature of Program Administrator (Date)

COURSE MEDICAL DIRECTOR: _____ Telephone #: _____

COURSE DIRECTOR: _____
(Last) (First) (M.I.)
E-mail: _____ Telephone #: _____

1. Certified/Licensed as an: EMT, EMT-Intermediate, AEMT, Paramedic, M.D./D.O. (please circle)
   Certificate/License Number: _____ Expiration Date: ___/___/___
2. Certified CPR Instructor with: [ ] AHA [ ] Red Cross Expiration Date: ___/___/___
3. Certified ACLS Provider. Expiration Date: ___/___/___ Instructor: Expiration Date: ___/___/___
4. Certified PHTLS or BTLS Provider. Expiration Date: ___/___/___ Instructor: Expiration Date: ___/___/___
5. Certified PEDS/ALS Provider. Expiration Date: ___/___/___ Instructor: Expiration Date: ___/___/___
6. Instructor Development Course. DPSST, NAEMSE 1, NFPA 1, Other: _____Date of Course: ___/___/___
7. Have at least three years experience in prehospital emergency medical care at or above the level of the course to be taught.

I certify that I am in good standing with my certifying/licensing agency(ies) and that I am not currently on probation for any reason.

I am aware of all Oregon Administrative Rules regarding requirements in this application and have answered all questions completely, without reservation of any kind, and I declare under penalty of perjury that my answers and all my qualifications herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial of the above listed EMT course. I further agree that, if I am a certified EMT, such act shall constitute cause for the suspension or revocation of my EMT certificate to practice as an emergency medical technician in the State of Oregon.

_____/____/____
(Signature of Course Director) (Date)

COURSE INSTRUCTOR (If different than Course Director): _____
(Last) (First) (M.I.)
E-mail: _____ Telephone #: _____

1. Certified/Licensed as an: EMT, AEMT, EMT-Intermediate, Paramedic, M.D./D.O. (please circle)
   Certificate/License Number: _____ Expiration Date: ___/___/___
2. Certified CPR Instructor with: [ ] AHA [ ] Red Cross Expiration Date: ___/___/___
3. Certified ACLS Provider. Expiration Date: ___/___/___ Instructor: Expiration Date: ___/___/___
4. Certified PHTLS or BTLS Provider. Expiration Date: ___/___/___ Instructor: Expiration Date: ___/___/___
5. Certified PEDS/ALS Provider. Expiration Date: ___/___/___ Instructor: Expiration Date: ___/___/___
6. Instructor Development Course. DPSST, NAEMSE 1, NFPA 1, Other: _____Date of Course: ___/___/___
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_____/____/_____
(Signature of Course Instructor) (Date)

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REQUEST PRACTICAL EXAMINATION

[ ] EMT [ ] AEMT [ ] EMT – I [ ] PARAMEDIC

EMS TRAINING INSTITUTION: _____

COURSE DIRECTOR: _____ Course Ending Date: _____/_____/_____

PRACTICAL EXAM INFORMATION:

Date: ___/___/___ Student Check-in: ____am/pm CO Arrival Time: _____am/pm

Location of exam: _____

Address: _____

Building/Room: _____

Contact Person: _____ Affiliation: _____

Daytime phone: _____ E-mail: _____

Medical Director _____ Daytime phone: _____