EMERGENCY MEDICAL TECHNICIAN TRAINING PROGRAM CRITERIA

I. AUTHORITY:

Sections 1797.107; 1797.109, 1797.170, 1797.173 Health and Safety Code. Title 22 Sections 100060, 100065 - 100078 , EMSA letter 8/13/2009 subj. Eligibility Criteria for EMT.

II. APPLICATION:

This policy describes the application process and curriculum requirements for approving an Emergency Medical Technician (EMT) training program.

III. POLICY:

A. OCEMS will follow regulations outlined in Title 22, Health & Safety Code and EMSA publications.

B. Eligibility for EMT training programs shall be limited to:

1. Accredited universities and colleges, including junior and community colleges, school districts and private post-secondary schools as approved by the State of California, Department of Consumer Affairs, Bureau of Private Postsecondary and Vocational Education.

2. Medical training units of a branch of the Armed Forces including the Coast Guard of the United States.

3. Licensed general acute care hospitals which meet criteria outlined in Title 22, Chapter 2, Section 100065.

4. Agencies of government including public safety agencies.

C. Institutions interested in applying to become an approved EMT training program should contact the EMS Licensing Desk at Orange County EMS (EMSLicensing@OCHCA.com) for an application packet (#510.00 Attachment 1). This packet can be found on the EMS website under EMS Policies.

IV. EMT PROGRAM REVIEW AND REPORTING:

A. All program materials shall be subject to periodic review by OCEMS.

B. All programs shall be subject to periodic on-site evaluation by OCEMS.

C. All approved EMT training programs shall notify OCEMS in writing, in advance when possible and in all cases within thirty (30) calendar days, of any change in program director, program clinical coordinator, principal instructor, assistant instructors, address, phone number, contact person and EMT skills competency verifiers.

D. If an EMT Training Program applicant cannot correct items of non-compliance within 30 days of a notice of deficiencies in the application process, their application will be ineligible for reconsideration for 180 days.

E. If there is evidence of intent to mislead the agency in the initial application, the application will be denied and ineligible for reconsideration for 730

F. Programs with multiple sites must complete an “EMT Training Program” application for each site, indicating the site address, principal instructor and teaching assistants.

V. FEES

A. Please refer to OCEMS policy #470.00 for all applicable fees applied to an initial or renewal EMT program application.

Approved:

Carl H. Schultz, MD OCEMS Medical Director	Tammi McConnell, MSN, RN OCEMS Administrator

Original Date: 01/1984
Reviewed Date(s): 09/02/2014; 4/1/2015; 7/25/2023
Revised Dates(s): 09/02/2014; 4/1/2015; 8/9/2023
Effective Date: 4/1/2015; 10/1/2023

APPROVAL PACKET

for

Emergency Medical Technician (EMT) Training Program

Emergency Medical Technician (EMT) Training Program

Approval Packet

California regulations require OCEMS to review prospective training programs to assure compliance with State regulations prior to approving the eligible institution's training program. Only approved training programs may offer the training listed below. The purpose of this document is to define the application requirements for Emergency Medical Technician (EMT) Training Program.

REQUIREMENTS FOR EMT TRAINING PROGRAM APPROVAL:

The eligibility and program requirements for Emergency Medical Training Programs are listed in California Code of Regulations (COR), Title 22. Social Security, Division 9. Prehospital Emergency Medical Services, Chapter 2. Emergency Medical Technician, Article 3. Sections 100065 - 100078 and referenced in the attached application and checklist.

Complete and submit OCEMS EMT Training Program approval forms and checklist for EMT Training Program Approval.

EMT TRAINING PROGRAM

I. PROCEDURES

A. Complete and submit the following to OCEMS:
- Application for EMT Training Program Approval
- Applicable Fees
- Checklist for EMT Training Program Approval
- Hospital/Ambulance Affiliation Information Form

B. The following should be retained by the Training Institution:
- Certification Exam, i.e., passing grade
- Attendance Requirements, etc.
- Certification Exam Eligibility, Clinical Time Verification Form

Application for EMT Training Program Approval

☐ **New** ☐ **Renewal** ☐ **Update**

Program Name ____________________

Mailing Address____________________**City**__________**ST**_____**ZIP**__________

Training Site(s) Address____________________**City**__________**ST**_____**ZIP**__________

Phone____________________**FAX**____________________

Website____________________**E-mail**____________________

Program Director____________________**Title**____________________

E-mail____________________

License Number____________________**Type**____________________

Include evidence of 40 hours in teaching methodology instruction in areas related to methods, materials, and evaluation of instruction.

Clinical Coordinator____________________**Title**____________________

E-mail____________________

License Number____________________**Type**____________________

Principal Instructor____________________**Title**____________________

E-mail____________________

License Number____________________**Type** ____________________

Attach required documents for all principal instructors as indicated in COR, Title 22, Division 9, Chapter 2, Section 100070.

Teaching Assistant____________________**Title**____________________

E-mail____________________

License Number____________________**Type** ____________________

Attach qualifications for teaching assistants.

Use separate page for additional principal instructor(s) and teaching assistant(s).

Attach Hospital and EMS Service Provider Contracts for clinical and field training.

Provider type (*check one*):

☐ Branch of the Armed Forces
☐ College or University
☐ Licensed acute care hospital
☐ Public safety agency
☐ Private post-secondary school
☐ School district/ROP
☐ Other: Specify ____________________

I certify that all information is accurate, to the best of my knowledge, and that I have read and understand the program responsibilities and expectations as outlined in COR, Title 22, Division 9, Chapter 2 (Emergency Medical Technician).

Signed, Program Director	Date

(OCEMS Use Only)

Date Application Received	Approval Date	Expiration Date	Receipt # / Date Paid

CHECKLIST FOR EMT TRAINING PROGRAM APPROVAL

	Materials to Submit for Program Approval	Page No.	Check Completed
1.	Table of Contents and checklist listing required information with corresponding page numbers (this form)		☐
2.	Application form for EMT training program approval		☐
3.	Statement of eligibility for training program approval		☐
4.	Written request to OCEMS for EMT training program approval		☐
5.	Statement verifying course content is equivalent to the US DOT National Emergency Medical Services Education Standards Emergency Medical Technician Instructional Guidelines (DOT HS 811 077A, January 2009)		☐
6.	Statement verifying CPR training equivalent to the current American Heart Association Guidelines at the Healthcare Provider level		☐
7.	Samples of written and skills examinations used for periodic testing		☐
8.	Final skills competency examination		☐
9.	Final written examination		☐
10.	Name and qualifications of the program director, program clinical coordinator, and principal instructor(s)		☐
11.	Evidence the course/program director has completed 40 hours in teaching methodology or equivalent per COR, Title 22, Division 9, Chapter 2, §100070		☐
12.	Provisions for course completion by challenge, including a challenge examination (if different from final examination)		☐
13.	Provisions for a 24 hour refresher required for renewal or reinstatement		☐
14.	Statement verifying usage of the US DOT EMT - Basic Refresher National Standard Curriculum (DOT HS 808 624, September 1996)		☐
15.	Location where courses are to be offered and the proposed dates		☐
16.	Copy of written agreement with 1 or more acute care hospital(s) to provide clinical experience, or		☐
17.	Copy of written agreement with 1 or more operational ambulance provider(s) to provide field experience		☐
18.	Application fees		☐

REQUIRED SUPPLIES FOR EMT TRAINING PROGRAM

REQUIRED SUPPLIES FORM TO BE COMPLTED BY OCEMS PERSONNEL

Required Supplies with Quantities		Check Completed
BSI Materials	☐ Gloves (1 Pair) ☐ Surgical Masks (1) ☐ N95s (1) ☐ Disposable Gowns (1) ☐ Goggles/Glasses (1)	☐
Spinal Immobilization Devices	☐ Adult C-Collar (Either Adjustable or 1 of Each Size) ☐ Pediatric C-Collar (1) ☐ Head Immobilizer (1) ☐ KED Device (1) ☐ Backboard with Straps (1)	☐
Trauma	☐ Trauma Tag (1)	☐
Airway Adjuncts	☐ Nasopharyngeal Airway Adjuncts (No Less the 4 Standard Sizes) ☐ Oropharyngeal Airway Adjuncts (1 of Each Size, Sizes 0-5) ☐ Water-Soluble Lubricant (1)	☐
Oxygen	☐ Adult BVM (1) ☐ Pediatric BVM (1) ☐ Infant BVM (1) ☐ Adult, Pediatric, & Infant Oxygen Non-Rebreather Masks (1 of Each) ☐ Adult & Pediatric Nasal Cannulas (1 of Each) ☐ Oxygen Cylinder & Regulator (1 of Each)	☐
Vital Signs	☐ Adult, Pediatric, and Infant Blood Pressure Cuff (1 of Each) ☐ Stethoscope (1) ☐ Training Glucometer (1) ☐ Pulse Oximeter (1) ☐ Pen Light (1) ☐ Thigh Blood Pressure Cuff (1) ***OPTIONAL***	☐

Suction Equipment	☐ Mechanical Portable Suction Device (1)
	    ☐ Tubing (1)
	    ☐ Yankauer (1)
	    ☐ Suction Catheter (1)
	****OR****
	☐ Manual Portable Suction Device (1)
	    ☐ Suction Catheter Attachment (1)
		☐

CPR & AED	☐ Adult & Infant CPR Manikin (1 of Each, Either Mechanical or Manual) ☐ AED Trainer with Adult & Pediatric AED Pads (1) ☐ Towel (1) ☐ Training Razor (1)	☐

REQUIRED SUPPLIES FOR EMT TRAINING PROGRAM

REQUIRED SUPPLIES FORM TO BE COMPLTED BY OCEMS PERSONNEL

Required Supplies		Check Completed
Hemorrhage Control	☐ 4" x 4" Dressings (1) ☐ Roller Gauze or Kerlix (1) ☐ Petroleum Gauze (1) ☐ Arterial Tourniquet (1) ☐ Triangular Bandage (1) ☐ 1", 2", 3" Tape (1 of Each) ☐ Trauma Sheers (1) ☐ Arm, Leg, and Wrist Cardboard Splint (1 of Each) ☐ Cold Pack, or Simulated Equivalent (1) ☐ Burn Blanket (1) ☐ Standard Blanket (1) ☐ Biohazard Bag (1)	☐
Epinephrine & Naloxone	☐ Epinephrine Auto-Injector Training Device (1) ☐ Naloxone Auto-Injector Training Device (1) ☐ Sharps Container (1)	☐

Obstetrical	☐ Obstetrical Kit (1)
	    ☐ Bulb Syringe (1)
	    ☐ Baby Blanket (1)
	    ☐ Towel (1)
	    ☐ Umbilical Cord Clamps (1)
	    ☐ Umbilical Cord Scissor (1)
	    ☐ Breslow Tape (1)
	☐ Childbirth Manikin ***OPTIONAL***
		☐

Traction Splint	☐ Adult Traction Splint (1) ☐ Pediatric Traction Splint (1)	☐
Ambulance Cot **OPTIONAL**	☐ Mechanical Ambulance Cot ***OPTIONAL*** ☐ Manual Ambulance Cot ***OPTIONAL***	☐
Manikin **OPTIONAL**	☐ Full Size Manikin ***OPTIONAL***	☐

EMT TRAINING PROGRAM HOSPITAL/AMBULANCE AFFILIATION INFORMATION

(ATTACH SIGNED AGREEMENT)

Name(s) of general acute care hospital(s) providing supervised in-hospital clinical experience for the EMT student.

Name: ____

Address: ____

County: ____

Liaison: ____

Title: ______________________ Phone: ______________________

E-mail: ______________________

Name: ____

Address: ____

County: ____

Liaison: ____

Title: ______________________ Phone: ______________________

E-mail: ______________________

Name(s) of ambulance provider agencies providing supervised instruction on an operational ambulance for the EMT student:

Level of Service

Name: ______________________________ ☐ ALS ☐ BLS

Address: ____

County: ____

Liaison: ____

Title: ______________________ Phone: ______________________

E-mail: ______________________

Name: ______________________________ ☐ ALS ☐ BLS

Address: ____

County: ____

Liaison: ____

Title: ______________________ Phone: ______________________

E-mail: ______________________