



**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 the 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 the 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** \_\_\_\_\_

**Website** \_\_\_\_\_

**Program Director** \_\_\_\_\_

**E-Mail Address** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

**License Number** \_\_\_\_\_ **License Type** \_\_\_\_\_

**Clinical Coordinator** \_\_\_\_\_

**E-Mail Address** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

**License Number** \_\_\_\_\_ **License Type** \_\_\_\_\_

**Training Site #1 Address** \_\_\_\_\_ **City** \_\_\_\_\_ **ST** \_\_\_\_\_ **ZIP** \_\_\_\_\_

**Is this Training Site 100% In-Classroom or Hybrid** \_\_\_\_\_

**If Hybrid, provide the number of hours in each:**                      **In-Classroom** \_\_\_\_\_ **Online** \_\_\_\_\_

**Principal Instructor For This Site** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

**E-mail** \_\_\_\_\_

**License Number** \_\_\_\_\_ **License Type** \_\_\_\_\_

**Teaching Assistant** \_\_\_\_\_ **Title** \_\_\_\_\_

**E-mail** \_\_\_\_\_

**License Number** \_\_\_\_\_ **License Type** \_\_\_\_\_

**Training Site #2 Address** \_\_\_\_\_ **City** \_\_\_\_\_ **ST** \_\_\_\_\_ **ZIP** \_\_\_\_\_

**Is this Training Site 100% In-Classroom or Hybrid** \_\_\_\_\_

**If Hybrid, provide the number of hours in each:**                      **In-Classroom** \_\_\_\_\_ **Online** \_\_\_\_\_

**Principal Instructor For This Site** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

**E-mail** \_\_\_\_\_

**License Number** \_\_\_\_\_ **License Type** \_\_\_\_\_

**Teaching Assistant** \_\_\_\_\_ **Title** \_\_\_\_\_

**E-mail** \_\_\_\_\_

**License Number** \_\_\_\_\_ **License Type** \_\_\_\_\_



Training Site #3 Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

Is this Training Site 100% In-Classroom or Hybrid \_\_\_\_\_

If Hybrid, provide the number of hours in each: In-Classroom \_\_\_\_\_ Online \_\_\_\_\_

Principal Instructor For This Site \_\_\_\_\_ Phone Number \_\_\_\_\_

E-mail \_\_\_\_\_

License Number \_\_\_\_\_ License Type \_\_\_\_\_

Teaching Assistant \_\_\_\_\_ Title \_\_\_\_\_

E-mail \_\_\_\_\_

License Number \_\_\_\_\_ License Type \_\_\_\_\_

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

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

Attach qualifications for teaching assistants.

Use a 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

Textbook Name and Edition \_\_\_\_\_

**List Below the Other Types of Teaching Materials you are Using for your EMT Program**

- 1 \_\_\_\_\_
- 2 \_\_\_\_\_
- 3 \_\_\_\_\_
- 4 \_\_\_\_\_
- 5 \_\_\_\_\_



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)		<input type="checkbox"/>
2.	Application form for EMT training program approval		<input type="checkbox"/>
3.	Statement of eligibility for training program approval (e.g., Accredited University, Community College, School District, Vocational Program. Private Post-Secondary School)		<input type="checkbox"/>
4.	A written request to OCEMS for EMT training program approval		<input type="checkbox"/>
5.	A 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). Statement of what curriculum would be used, listing textbook(s) and year(s) of publication.		<input type="checkbox"/>
6.	Schedule of courses and method by which they will be taught (Full Classroom, Hybrid)		<input type="checkbox"/>
7.	Statement verifying CPR training equivalent to the current American Heart Association Guidelines at the Healthcare Provider level		<input type="checkbox"/>
8.	Statement that written final examination, chapter examinations and quizzes are kept on file and available for review.		<input type="checkbox"/>
9.	Submit individual skills competency and final skills competency examinations.		<input type="checkbox"/>
10.	Name and qualifications of the program director, program clinical coordinator, and principal instructor(s)		<input type="checkbox"/>
11.	Evidence the course/program director and principal instructor have completed 40 hours in teaching methodology or equivalent per COR, Title 22, Division 9, Chapter 2, §100070		<input type="checkbox"/>
12.	Provisions for course completion by challenge, including a challenge examination (if different from the final examination)		<input type="checkbox"/>
13.	Provisions for a 24-hour refresher required for renewal or reinstatement		<input type="checkbox"/>
14.	Statement verifying usage of the US DOT EMT - Basic Refresher National Standard Curriculum (DOT HS 808 624, September 1996)		<input type="checkbox"/>
15.	Address of where the EMT program is located and where courses will be taught. (If the program has multiple locations, page 3 of this application must be completed for each location)		<input type="checkbox"/>
16.	Copy of written agreement with 1 or more acute care hospital(s) or operational ambulance provider(s) to provide clinical experience		<input type="checkbox"/>
17.	Application fees		<input type="checkbox"/>



# REQUIRED SUPPLIES FOR EMT TRAINING PROGRAM

## REQUIRED SUPPLIES FORM TO BE COMPLETED BY OCEMS PERSONNEL

Required Supplies with Quantities		Check Completed
BSI Materials	<input type="checkbox"/> Gloves (1 Pair) <input type="checkbox"/> Surgical Masks (1) <input type="checkbox"/> N95s (1) <input type="checkbox"/> Disposable Gowns (1) <input type="checkbox"/> Goggles/Glasses (1)	<input type="checkbox"/>
Spinal Immobilization Devices	<input type="checkbox"/> Adult C-Collar (Either Adjustable or 1 of Each Size) <input type="checkbox"/> Pediatric C-Collar (1) <input type="checkbox"/> Head Immobilizer (1) <input type="checkbox"/> KED Device (1) <input type="checkbox"/> Backboard with Straps (1)	<input type="checkbox"/>
Trauma	<input type="checkbox"/> Trauma Tag (1)	<input type="checkbox"/>
Airway Adjuncts	<input type="checkbox"/> Nasopharyngeal Airway Adjuncts (No Less the 4 Standard Sizes) <input type="checkbox"/> Oropharyngeal Airway Adjuncts (1 of Each Size, Sizes 0-5) <input type="checkbox"/> Water-Soluble Lubricant (1)	<input type="checkbox"/>
Oxygen	<input type="checkbox"/> Adult BVM (1) <input type="checkbox"/> Pediatric BVM (1) <input type="checkbox"/> Infant BVM (1) <input type="checkbox"/> Adult, Pediatric, & Infant Oxygen Non-Rebreather Masks (1 of Each) <input type="checkbox"/> Adult & Pediatric Nasal Cannulas (1 of Each) <input type="checkbox"/> Oxygen Cylinder & Regulator (1 of Each)	<input type="checkbox"/>
Vital Signs	<input type="checkbox"/> Adult, Pediatric, and Infant Blood Pressure Cuff (1 of Each) <input type="checkbox"/> Stethoscope (1) <input type="checkbox"/> Training Glucometer (1) <input type="checkbox"/> Pulse Oximeter (1) <input type="checkbox"/> Pen Light (1) <input type="checkbox"/> Thigh Blood Pressure Cuff (1) <b>*OPTIONAL*</b>	<input type="checkbox"/>
Suction Equipment	<input type="checkbox"/> Mechanical Portable Suction Device (1) <ul style="list-style-type: none"> <li><input type="checkbox"/> Tubing (1)</li> <li><input type="checkbox"/> Yankauer (1)</li> <li><input type="checkbox"/> Suction Catheter (1)</li> </ul> <b>**OR**</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Manual Portable Suction Device (1)</li> <li><input type="checkbox"/> Suction Catheter Attachment (1)</li> </ul>	<input type="checkbox"/>
CPR&AED	<input type="checkbox"/> Adult & Infant CPR Manikin (1 of Each, Either Mechanical or Manual) <input type="checkbox"/> AED Trainer with Adult & Pediatric AED Pads (1) <input type="checkbox"/> Towel (1) <input type="checkbox"/> Training Razor (1)	<input type="checkbox"/>



## REQUIRED SUPPLIES FOR EMT TRAINING PROGRAM

### REQUIRED SUPPLIES FORM TO BE COMPLETED BY OCEMS PERSONNEL

Required Supplies		Check Completed
Hemorrhage Control	<input type="checkbox"/> 4" x 4" Dressings (1) <input type="checkbox"/> Roller Gauze or Kerlix (1) <input type="checkbox"/> Petroleum Gauze (1) <input type="checkbox"/> Arterial Tourniquet (1) <input type="checkbox"/> Triangular Bandage (1) <input type="checkbox"/> 1", 2", 3" Tape (1 of Each) <input type="checkbox"/> Trauma Sheers (1) <input type="checkbox"/> Arm, Leg, and Wrist Cardboard Splint (1 of Each) <input type="checkbox"/> Cold Pack, or Simulated Equivalent (1) <input type="checkbox"/> Burn Blanket (1) <input type="checkbox"/> Standard Blanket (1) <input type="checkbox"/> Biohazard Bag (1)	<input type="checkbox"/>
Epinephrine & Naloxone	<input type="checkbox"/> Epinephrine Auto-Injector Training Device (1) <input type="checkbox"/> Naloxone Auto-Injector Training Device (1) <input type="checkbox"/> Sharps Container (1)	<input type="checkbox"/>
Obstetrical	<input type="checkbox"/> Obstetrical Kit (1) <ul style="list-style-type: none"> <li><input type="checkbox"/> Bulb Syringe (1)</li> <li><input type="checkbox"/> Baby Blanket (1)</li> <li><input type="checkbox"/> Towel (1)</li> <li><input type="checkbox"/> Umbilical Cord Clamps (1)</li> <li><input type="checkbox"/> Umbilical Cord Scissor (1)</li> <li><input type="checkbox"/> Breslow Tape (1)</li> </ul> <input type="checkbox"/> Childbirth Manikin <b>*OPTIONAL*</b>	<input type="checkbox"/>
Traction Splint	<input type="checkbox"/> Adult Traction Splint (1) <input type="checkbox"/> Pediatric Traction Splint (1)	<input type="checkbox"/>
Ambulance Cot <b>OPTIONAL</b>	<input type="checkbox"/> Mechanical Ambulance Cot <b>*OPTIONAL*</b> <input type="checkbox"/> Manual Ambulance Cot <b>*OPTIONAL*</b>	<input type="checkbox"/>
Manikin <b>OPTIONAL</b>	<input type="checkbox"/> Full Size Manikin <b>*OPTIONAL*</b>	<input type="checkbox"/>





# 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 #1: \_\_\_\_\_  ALS  BLS

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

County: \_\_\_\_\_

Liaison: \_\_\_\_\_

Title: \_\_\_\_\_ Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**Level of Service**

Name #2: \_\_\_\_\_  ALS  BLS

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

County: \_\_\_\_\_

Liaison: \_\_\_\_\_

Title: \_\_\_\_\_ Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_



**Level of Service**

OCEMS P/P #510.00  
Attachment I

Name #3: \_\_\_\_\_  ALS  BLS

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

County: \_\_\_\_\_

Liaison: \_\_\_\_\_

Title: \_\_\_\_\_ Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**Level of Service**

Name #4: \_\_\_\_\_  ALS  BLS

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

County: \_\_\_\_\_

Liaison: \_\_\_\_\_

Title: \_\_\_\_\_ Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_