# APPROVAL PACKET

# for

# Emergency Medical Technician (EMT) Training Program

# Emergency Medical Technician (EMT) Training Program

# Approval Packet

**California regulations require OCEMS to review prospective and renewing 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 Emergency Medical Services Authority (EMSA) Code of Regulations (COR), Title 22. Social Security, Division 9. Prehospital Emergency Medical Services, Chapter 3.1, Emergency Medical Technician, Article 3. Sections 100067.01 – 100067.14" and referenced in the attached application and checklist. It is the applicant's responsibility to review the EMSA regulations to verify they meet program requirements.

## EMT TRAINING PROGRAM

I. **PROCEDURES**

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

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

## EMT PROGRAM RELATED POLICIES

It is the responsibility of the approved E.M.T. programs to review and comply with the following Orange County Emergency Medical Services policies:

#510.00 Emergency Medical Technician Training Criteria
#510.05 EMS Monitoring of Approved Training Programs
#510.10 EMT Skills Competency Verification Process (Including attachments A and B)
#530.00 EMS Continuing Education (CE) Provider Approval (Including attachments 1 and 2)

# Application for EMT Training Program Approval

☐ New ☐ Renewal ☐ Update

**Program Name** _____

**Mailing Address** _____ **City** _____ **ST** _____ **ZIP** _____

**Website** _____

## EMT Program Owner / College Administrator / Trade School Administrator Information

**Name** _____ **Phone Number** _____ **E-Mail Address** _____

**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 3.1, Section 100067.06.

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 3.1 (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. | Completed application | | ☐ |
| 3. | A written request to OCEMS for EMT training program approval | | ☐ |
| 4. | Statement and proof of eligibility for training program approval (e.g., Accredited University, Community College, School District, Vocational Program, Bureau of Private Post-Secondary School, Armed Forces, GAC Hospital) | | ☐ |
| 5. | A statement verifying usage of the US DOT National EMS Education Standards Emergency Medical Technician Instructional Guidelines (DOT HS 811 077A, January 2009). Provide list of textbook(s) and edition(s) along with all other curriculum. | | ☐ |
| 6. | Location and schedule of courses and method by which they will be taught (Full in Classroom, Hybrid) | | ☐ |
| 7. | Statement verifying CPR training equivalent to the current American Heart Association Guidelines at the Healthcare Provider level and is a prerequisite for admission to EMT course. | | ☐ |
| 8. | Statement that written final examination, chapter examinations and quizzes are kept on file and available for review. | | ☐ |
| 9. | Submit individual skills competency and final skills competency examinations. | | ☐ |
| 10. | Name and qualifications of the program director, program clinical coordinator, and principal instructor(s) | | ☐ |
| 11. | Evidence the course program director and principal instructor/s have completed 40 hours in teaching methodology or equivalent per COR, Title 22, Division 9, Chapter 3.1, §100067.06. | | ☐ |
| 12. | Provisions for course completion by challenge, including a challenge examination (if different from the final examination) | | ☐ |
| 13. | Provisions for a 24-hour refresher course for recertification using the U.S. DOT EMT-Basic Refresher National Standard Curriculum, DOT HS 808 624, September 1996. | | ☐ |
| 14. | Address(s) of EMT program training site(s) where courses will be taught. (If the program has multiple locations, page 3 of this application must be completed for each location). | | ☐ |
| 15. | Copy of written agreement with 1 or more general acute care hospital(s) or operational ambulance provider(s) to provide clinical experience | | ☐ |
| 16. | List of programs EMT skills competency verifiers (list must be updated anytime there is a change | | ☐ |
| 17. | Application fees will be invoiced by the Orange County Healthcare Agency. (See policy 470.00 for amount) | | ☐ |

# 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)<br>☐ Surgical Masks (1)<br>☐ N95s (1)<br>☐ Disposable Gowns (**1**)<br>☐ Goggles/Glasses (1) | ☐ |
| Spinal Immobilization Devices | ☐ Adult C-Collar (Either Adjustable or 1 of Each Size)<br>☐ Pediatric C-Collar (I)<br>☐ Head Immobilizer (1)<br>☐ KED Device (1)<br>☐ Backboard with Straps (I) | ☐ |
| Trauma | ☐ Trauma Tag (1) | ☐ |
| Airway Adjuncts | ☐ Nasopharyngeal Airway Adjuncts (No Less the 4 Standard Sizes)<br>☐ Oropharyngeal Airway Adjuncts (1 of Each Size, Sizes 0-5)<br>☐ Water-Soluble Lubricant (1) | ☐ |
| Oxygen | ☐ Adult BVM **(1)**<br>☐ Pediatric BVM (1)<br>☐ Infant BVM (1)<br>☐ Adult, Pediatric, & Infant Oxygen Non-Rebreather Masks (1 of Each)<br>☐ Adult & Pediatric Nasal Cannulas (1 of Each)<br>☐ Oxygen Cylinder & Regulator (1 of Each) | ☐ |
| Vital Signs | ☐ Adult, Pediatric, and Infant Blood Pressure Cuff (1 of Each)<br>☐ Stethoscope (1)<br>☐ Training Glucometer (1)<br>☐ Pulse Oximeter (**1**)<br>☐ Pen Light (**1**)<br>☐ Thigh Blood Pressure Cuff (1) ***OPTIONAL*** | ☐ |
| Suction Equipment | ☐ Mechanical Portable Suction Device (1)<br>☐ Tubing (1)<br>☐ Yankauer (1)<br>☐ Suction Catheter (1)<br>****OR****<br>☐ Manual Portable Suction Device (1)<br>☐ Suction Catheter Attachment (1) | ☐ |
| CPR&AED | ☐ Adult & Infant CPR Manikin (1 of Each, Either Mechanical or Manual)<br>☐ AED Trainer with Adult & Pediatric AED Pads (1)<br>☐ Towel (1)<br>☐ 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)<br>☐ Roller Gauze or Kerlix (1)<br>☐ Petroleum Gauze (1)<br>☐ Arterial Tourniquet (1)<br>☐ Triangular Bandage (1)<br>☐ 1", 2", 3" Tape (1 of Each)<br>☐ Trauma Sheers (1)<br>☐ Arm, Leg, and Wrist Cardboard Splint (1 of Each)<br>☐ Cold Pack, or Simulated Equivalent (1)<br>☐ Burn Blanket (1)<br>☐ Standard Blanket (1)<br>☐ Biohazard Bag (1) | ☐ |
| Epinephrine & Naloxone | ☐ Epinephrine Auto-Injector Training Device (1)<br>☐ Naloxone Auto-Injector Training Device **(1)**<br>☐ Sharps Container (1) | ☐ |
| Obstetrical | ☐ Obstetrical Kit (1)<br>☐ Bulb Syringe (1)<br>☐ Baby Blanket (1)<br>☐ Towel (1)<br>☐ Umbilical Cord Clamps (1)<br>☐ Umbilical Cord Scissor (1)<br>☐ Breslow Tape (1)<br>☐ Childbirth Manikin ***OPTIONAL*** | ☐ |
| Traction Splint | ☐ Adult Traction Splint (1)<br>☐ Pediatric Traction Splint (1) | ☐ |
| IV Monitor and Set Up | ☐ IV Bag Solution<br>☐ IV Tubing Set (Spike Kit) | ☐ |
| Ambulance Cot **OPTIONAL** | ☐ Mechanical Ambulance Cot ***OPTIONAL***<br>☐ 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 #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**

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: _____