ADVANCED EMERGENCY MEDICAL TECHNICIAN (AEMT) TRAINING COURSE AUTHORIZATION REQUEST

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES & TRAUMA
SFN 53364 (1/2016)

Instructions: Type or print clearly. This request must be completed by the course coordinator and submitted to DEMST at least **two weeks** prior to beginning the course. Please keep a copy for your records.

Type of Training (check one)	☐ AEMT - Initial		
Physical location of course (ambulance hall, fire hall, etc.)			
Address	City	State	Zip Code
Start Date	End Date	Estimated Hours:	
Course will be held on: (Check all that apply)	☐ Su ☐ M ☐ Tu ☐ W ☐ Th ☐ F ☐ Sa	Meeting Time	
Course Coordinator (Paramedic Only)	State EMS #		
Address	City	State	Zip Code
E-Mail	Telephone Number		
Primary Instructor	State EMS #		
Physician Medical Director			
Textbook Used	Publisher	Edition	
State Practical Test Site Date (Initial AEMT only)			
☐ Open Course ☐ Closed Course	If 'open', list contact person	Telephone Number	
ALS Licensed Ambulance Service (for clinical purposes)			
Name of participating hospital (for clinical purposes)			

Please check all of the materials you wish to receive below. If nothing is checked, no materials will be sent. Please note - ony one copy of each document will be supplied by DEMST. The individual listed as course coordinator will receive all necessary paperwork to conduct this course.

☐ Roster	☐ Student EMS Registration Form	☐ Practical Tests Application (Bismarck site)

As course coordinator I will secure course materials and visual aids, secure use of classroom facilities, prepare and implement class schedules, arrange and schedule in-hospital observation and training, and perform other appropriate class functions. I will adhere to the appropriate standard curriculum throughout the course as well as adhering to DEMST security requirements. A schedule must be submitted with request for initial courses.

Signature	Date

A COURSE AUTHORIZATION NUMBER WILL BE INCLUDED IN THE COURSE AUTHORIZATION LETTER UPON APPROVAL
PLEASE KEEP THIS NUMBER FOR YOUR RECORDS AND USE ON ALL COURSE CORRESPONDENCE
PLEASE NOTE: AN EMS REGISTRATION FORM MUST BE COMPLETED FOR EACH STUDENT AND SUBMITTED WITH THE ROSTER UPON COURSE COMPLETION FOR REFRESHER COURSES.
AN EMS REGISTRATION FORM MUST BE COMPLETED FOR EACH STUDENT AT THE BEGINNING OF INITIAL COURSES.

DEMST USE ONLY

Course Authorization #	Course Authorization #
Posted on website	Handouts sent

ADVANCED EMERGENCY MEDICAL TECHNICIAN - AEMT
MEDICAL DIRECTOR AGREEMENT

Initial Courses Only

EMS Training Program:		
Physician Name		
Mailing Address		
City	State	Zip Code

Responsibilities of Physician Medical Director

-Obtain approval from the hospital medical staff(s) (providing clinical training) to initiate an Advanced Emergency Medical Technician Course

-Assure overall direction and coordination of the planning, organization, administration, periodic review, continued development and effectiveness of the program

-Oversee that the course is conducted as outlined in the Education Standards

-Oversee the quality of instruction and clinical experience

-Oversee course compliance with all applicable board regulations

-Critique patient care during training and assure maintenance of written documentation of same

-Participate in review of student applications and selection

-Review results of interim examinations

As Physician Medical Director of the Advanced Emergency Medical Technician (AEMT) course I agree to previous mentioned responsibilities and reserve the right to withdraw this agreement at any time. In order to withdraw this agreement it must be submitted in writing to the Division of EMS and Trauma (DEMST).

_____	_____
Signature of Physician Medical Director	Date

_____
ND License Number

ADVANCED EMERGENCY MEDICAL TECHNICIAN - AEMT
HOSPITAL ADMINISTRATION SUPPORT

Initial Courses Only

EMS Training Program:		
Hospital Name		
Mailing Address		
City	State	Zip Code
Hospital Administrator		

As administrator of above mentioned hospital, I support the initiation of an Advanced Emergency Medical Technician (AEMT) Training Program and agree that the students enrolled in this program may do their clinical training skills in this hospital. I may withdraw this agreement at any time by submitting the request in writing to the Training Program Director and the Division of EMS and Trauma (DEMST).

_____	_____
Signature of Hospital Administrator	Date

ADVANCED EMERGENCY MEDICAL TECHNICIAN - AEMT
ALS AMBULANCE SERVICE SUPPORT

Initial Courses Only

EMS Training Program:		
Service Name		
Mailing Address		
City	State	Zip Code
Director/Manager		

As director of above mentioned ambulance service I agree to provide a setting for conducting the ALS clinical for the AEMT training program to be held at named city. I understand the ALS ambulance experience will involve the AEMT students observing and participating under supervision in all aspects of patient care as carried out by this service. The ambulance clinical experience will be under the supervision of the medical director of the service on record. I understand this agreement may be terminated under written notice to the training program director and the Division of EMS and Trauma.

_____	_____
Signature of Ambulance Service Director / Manager	Date