ENHANCED SKILL ROSTER / PHYSICIAN AUTHORIZATION

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES & TRAUMA
SFN 61033 (3/2016)

Course Authorization Number (If applicable)		Course Type
Course Coordinator License Number	Course Start Date	Course End Date
Course Location (City)		

State EMS License Number	Full Name	Level	Written	Practical
1			☐ Pass	☐ Pass
2			☐ Pass	☐ Pass
3			☐ Pass	☐ Pass
4			☐ Pass	☐ Pass
5			☐ Pass	☐ Pass
6			☐ Pass	☐ Pass
7			☐ Pass	☐ Pass
8			☐ Pass	☐ Pass
9			☐ Pass	☐ Pass
10			☐ Pass	☐ Pass
11			☐ Pass	☐ Pass
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13			☐ Pass	☐ Pass
14			☐ Pass	☐ Pass
15			☐ Pass	☐ Pass
16			☐ Pass	☐ Pass
17			☐ Pass	☐ Pass
18			☐ Pass	☐ Pass
19			☐ Pass	☐ Pass
20			☐ Pass	☐ Pass

The above named person(s) are affiliated with _____(ambulance service, rescue squad, etc.) within the geographic area of my practice. These persons are allowed to provide the ALS skills designated by me as part of my practice and only as a result of my delegation of the authority to do so. The above named person(s) must also have current certification to perform named skill. I may revoke this authority at any time. If I do so, I will provide the Division of Emergency Medical Services with written notification of the revocation.
This document expires June 30, 20____

Physician Name	Medical License #
Physician Signature	Date

Remember to submit EMS Registration forms if applicable for your course.

By signing below I hereby certify that all information stated above is true and correct.

Signature of Course Coordinator	Date

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMS AND TRAUMA
1720 BURLINGTON DR
BISMARCK, ND 58504