



EMS COURSE ROSTER / PHYSICIAN AUTHORIZATION

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SYSTEMS
SFN 52195 (02/2021)



Enhanced skills authorization MUST be signed by a physician. Remember to submit EMS Registration forms for your course if applicable.

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
12			Pass	Pass
13			Pass	Pass
14			Pass	Pass
15			Pass	Pass
16			Pass	Pass
17			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 Systems with written notification of the revocation.

This document expires June 30, 20____

Physician Name	Medical License Number
Physician Signature	Date

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

Signature of Course Coordinator	Date
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