Approved Signatures for EMT Skills Verification of Competency

Provider Agency/ Training Program:	
Mailing Address:	
Phone:	**Fax:**
Program Manager/ Director:	**Email:**
CE Provider Number (if applicable):	**Expiration Date**:

The following individuals are affiliated with our agency/ program and are approved to verify skills competency:

Name of Employee	Certification / License Number

(Please notify the EMS Agency within 30 days of any changes)

Program Manager/ Director Approval Signature: _____
Date: _____