WREMAC

AEMT

Mandatory Annual Skills Evaluation Form

Name: _____ Date: _____

Certification #: _____ CPR Expiration: _____

Certification Expiration: _____ TLS Expiration: _____

Primary EMS Agency: _____

Email Address: _____

			Circle Method Used to Demonstrate Skill (See options below)		
Defibrillation	Date: _____	Evaluator: _____	**1**	**2**	**3**
Intranasal Naloxone *	Date: _____	Evaluator: _____	**1**	**2**	**3**
BLS Epi (Epi-Pen/Syringe) *	Date: _____	Evaluator: _____	**1**	**2**	**3**
Blood Glucose Monitoring*	Date: _____	Evaluator: _____	**1**	**2**	**3**
Nebulized Albuterol *	Date: _____	Evaluator: _____	**1**	**2**	**3**
BLS EKG Monitoring*	Date: _____	Evaluator: _____	**1**	**2**	**3**
CPAP*	Date: _____	Evaluator: _____	**1**	**2**	**3**
Peripheral IV – Adult	Date: _____	Evaluator: _____	**1**	**2**	**3**
IO – Adult & Pediatric	Date: _____	Evaluator: _____	**1**	**2**	**3**
Alternate Airway Devices	Date: _____	Evaluator: _____	**1**	**2**	**3**
IV Bolus Med Admin	Date: _____	Evaluator: _____	**1**	**2**	**3**
IM Med Admin	Date: _____	Evaluator: _____	**1**	**2**	**3**
Oral Intubation – Adult	Date: _____	Evaluator: _____	**1**	**2**	**3**

*** Demonstrated only if agency is approved to use the skill**

Annual Skills Verification (Evaluator): _____ _____

Print Signature

Provider's Signature: _____

Medical Director's Name: _____

Skill competency shall be demonstrated to the medical director (or his designee), as follows:

1. Demonstrate the skill **2.** Verified the skill from QA/QI **3.** Attending an approved Medical Director training

****A copy of this summary must be maintained in each providers agency file****

Updated January 2020