WREMAC

CFR and EMT

Mandatory Annual Skills Evaluation Form

Name: _____ Date: _____

Certification #: _____ CPR Expiration: _____

Certification Expiration: _____

Primary EMS Agency: _____

Email Address: _____

Circle Method Used to Demonstrate Skill (See options below)

Certified First Responder Skills Evaluation

Defibrillation	Date: _____	Evaluator: _____	**1**	**2**	**3**
Intranasal Naloxone *	Date: _____	Evaluator: _____	**1**	**2**	**3**
BLS Epi (Epi-Pen/Syringe) *	Date: _____	Evaluator: _____	**1**	**2**	**3**

EMT Skills Evaluation

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**

***Demonstrate only if the 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 skills **2.** Verified the skills 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