



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

AED	Date: _____	Evaluator: _____	1	2	3
BLS Naloxone *	Date: _____	Evaluator: _____	1	2	3
Epi-Pen *	Date: _____	Evaluator: _____	1	2	3

EMT Skills Evaluation

AED	Date: _____	Evaluator: _____	1	2	3
BLS Naloxone *	Date: _____	Evaluator: _____	1	2	3
Nebulized Albuterol *	Date: _____	Evaluator: _____	1	2	3
Blood Glucose Monitoring*	Date: _____	Evaluator: _____	1	2	3
BLS EKG Acquisition*	Date: _____	Evaluator: _____	1	2	3
Epi-Pen *	Date: _____	Evaluator: _____	1	2	3
IM Syringe Epi*	Date: _____	Evaluator: _____	1	2	3
CPAP*	Date: _____	Evaluator: _____	1	2	3

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

Annual Skills Verification (Evaluator): _____

Print
Signature

Provider Signature: _____

Medical Director 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 Med Dir training

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