Advanced Practice Skills Checkoff

Paramedic

Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMS Certification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
| **Advanced Practice Skill/Medication** | **Allowed to Perform?** | **Date Completed** |
| BEFAST Stroke Scale | Yes No |  |
| CPAP/BIPAP | Yes No |  |
| Pediatric Intubation (<12 years) | Yes No |  |
| Transport Ventilator- Initiate/Manage (THEORY ONLY, no skills) | Yes No |  |
| Anesthetic/Sedative: General maintenance of intubated patient (Versed) | Yes No |  |
| Delayed/Rapid Sequence Intubation (DSI/RSI) | Yes No |  |
| Anesthetic/Sedative: General Initiate (Etomidate) | Yes No |  |
| Anesthetic/Sedative: Ketamine - Sedation/Restraint | Yes No |  |
| Neuromuscular Blockers- Vecuronium/Rocuronium | Yes No |  |

I certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has successfully completed the above indicated Advanced Practice skills training for the **PARAMEDIC** level.

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Agency Administrator Name Agency Administrator Signature Date

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I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to perform the above Advanced Practice Skills.

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EMS Physician Name EMS Physician Signature Date