



OFFICIAL USE ONLY

COURSE NUMBER APPROVAL

TENNESSEE DEPARTMENT OF HEALTH  
DIVISION OF HEALTH LICENSURE AND REGULATION  
OFFICE OF EMERGENCY MEDICAL SERVICES

**APPLICATION FOR COURSE APPROVAL**

(MUST BE SUBMITTED AT LEAST THIRTY (30) DAYS PRIOR TO CLASS START DATE)

Date: \_\_\_\_\_

**CHECK ONE:**  EMR  EMT  AEMT  PARAMEDIC  EMD  VENTILATOR TRAINING  
 PARAMEDIC-CRITICAL CARE

**CHECK ONE:**  INITIAL  REFRESHER

***COPY OF CLASS SCHEDULE REQUIRED WITH APPLICATION***

**Please type or print**

Sponsoring Institution: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City/Town State Zip

Program Director: \_\_\_\_\_ Contact Telephone#: \_\_\_\_\_

Email Address: \_\_\_\_\_

Campus Location: \_\_\_\_\_ Classroom Location: \_\_\_\_\_

Beginning Date: \_\_\_\_\_ Requested Practical Date: \_\_\_\_\_ Class Hours: \_\_\_\_\_ to \_\_\_\_\_

Anticipated Enrollment: \_\_\_\_\_ ***NOT TO EXCEED 12 STUDENTS PER LAB SESSION PER INSTRUCTOR***

Medical Director: \_\_\_\_\_ Lead Instructor/Coordinator: \_\_\_\_\_

Co- Instructors: \_\_\_\_\_

We jointly agree that the stated course will be conducted in accordance with the policies, standards and requirements as set forth in the EMS statutes, Rules and Regulations, and the Office of EMS Training Policy.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Program Director)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(EMS Consultant)