TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF EMERGENCY MEDICAL SERVICES

EMERGENCY MEDICAL RESPONDER
PRACTICAL SKILLS VERIFICATION

Student Name: _____ **Social Security #:** _____

Training Agency: _____ **Class Number:** _____

SKILL	DATE (mm/dd/yyyy)	SATISFACTORY	INSTRUCTOR INITIALS
PATIENT ASSESSMENT			
Medical			
Trauma			
Documentation			
OXYGEN ADMINISTRATION			
O2 Administration			
AIRWAY ADJUNCTS			
Oral Airways			
Bag-Valve-Mask			
Pocket Mask			
BANDAGING			
Eye Irrigation and Bandage			
Head			
Amputation			
SPLINTING			
Sling and Swathe			
Cervical Immobilization			
Radius/Ulna Board			
Tibia/Fibula Board			
Hip			
Spinal Immobilization			
BLEEDING CONTROL			
Direct Pressure			
Tourniquet			
ASSISTING			
Clam Shell Device			
Scoop Stretcher			
Traction Splinting			
Ambulance Cot Operations			
CARDIAC ARREST MANAGEMENT			
CPR (expiration date _____)			
AED			

This individual has demonstrated knowledge and skill competencies in the above listed procedures and has met all course attendance and completion requirements.

_____ _____

Instructor Printed Name Date Instructor Signature

I acknowledge that I have performed and practiced each of the skills listed above.

_____ _____

Students Printed Name Date Signature of Student