Clear Print

PARAMEDIC TRAINING PROGRAM

Program Approval

☐ Initial Application ☐ Renewal ☐ Program Change

TRAINNG PROGRAM FEES: Agencies of Government, Hospitals, and Community Colleges **$2,250.00**

Private Programs **$4,500.00**

PARAMEDIC TRAINING PROGRAM NAME: _____

PROVIDER LOCATION (County of primary headquarters)**:** _____

MAILING ADDRESS: _____ _____ _____ _____

Street City State Zip

PHONE NUMBER: _____ **FAX NUMBER:** _____

PROGRAM DIRECTOR: _____

PROGRAM MEDICAL DIRECTOR: _____

ELIGIBILITY (Provide Documentation)**:**

☐ Accredited universities and colleges including junior and community colleges, school districts, and private post-secondary schools

☐ Medical training units of a branch of the Armed Forces or the Coast Guard of the United States

☐ Licensed general acute care hospitals

☐ Agencies of government including public safety agencies -

STUDENT ELIGIBILITY: ☐ Employees only ☐ Open to the public

CONTINUING EDUCATION PROVIDER: Training Programs wishing approval as a Continuing Education Provider should complete Continuing Education Provider Application. CE provider requirements can be found in Title 22, Division 9, Chapter 11.

LOCAL EMS AGENCY AUTHORITY: All training programs located in Alameda County, regardless of where headquartered or approved, are required to submit on an on-going basis, up-to-date training program information, including program director, clinical coordinators, principle instructors, class schedules, and rosters; and may be audited for compliance with regulations.

I certify that I have read and understand the requirements in Title 22, Chapter 4, Article 3 to be an approved Paramedic Training Program, and will comply with the requirements as described. I certify that all information on this application, to the best of my knowledge, is true and correct. I understand that failure to comply with the requirements in Title 22 may result in revocation of this program approval.

Program Director Signature: _____ **Date:** _____

(MM/DD/YYYY)

For Alameda County EMS Use Only

Application Received	Application Incomplete - Returned	Application Approved	Expiration Date	Reviewed By

Comments: _____

PARAMEDIC TRAINING PROGRAM

Application Check-list

The following material must be submitted with your initial or renewal application form. Failure to provide the required material within the required timeframe will delay your approval or re-approval as a Paramedic Training Program. Shaded areas not required.

Material to be submitted:	Initial program	Program Renewal	EMS agency use
Application Form	☐	☐	☐
Eligibility Documentation	☐		☐
Program Fees	☐	☐	☐
Program Director documentation	☐	☐	☐
Program Medical Director Documentation	☐	☐	☐
Principal Instructor(s) documentation	☐	☐	☐
Teaching Assistants documentation	☐	☐	☐
Written agreement(s) with paramedic service provider(s) for student field internships	☐		☐
Written agreement(s) with licensed general acute hospital(s) for student clinicals	☐		☐
A statement identifying which Paramedic curriculum is used (equivalent to the U.S. DOT EMT-P National Standard Curriculum HS 808 862 March 1999)	☐	☐	☐
A statement attesting to the number of course hours (broken down by didactic and skills, and hospital clinical and field internships)	☐	☐	☐
An outline of course objectives	☐	☐	☐
Performance objectives for each skill	☐	☐	☐
Student evaluation criteria and standardized forms for evaluating students and monitoring of preceptors in the hospital setting	☐	☐	☐
Student evaluation criteria and standardized forms for evaluating students and monitoring of preceptors in a field internship setting	☐	☐	☐
Sample of tamper resistant course completion certificate	☐		☐
Samples of skills examinations for periodic testing and a copy of a final written examination	☐	☐	☐
Statements describing the facilities and equipment, and provisions for examination security and student record keeping	☐		☐
The location of courses and proposed start dates	☐		☐
A statement of the anticipated submission date of materials to CoAEMSP for CAAHEP accreditation	☐		☐
Copies of the pre-enrollment letter provided to applicants explaining the CAAHEP accreditation process	☐		☐
A calendar of courses given in the past year showing dates of courses		☐	☐

Not Required

PARAMEDIC TRAINING PROGRAM

PROGRAM DIRECTOR INFORMATION SHEET

Name: _____ _____ _____
Last First MI

Agency: _____

Address: _____ _____ _____ _____
Street City State Zip

Home Phone: _____ **Cell Phone:** _____ **Fax:** _____

E-mail: _____

Qualifications - Each Paramedic Training Program shall have an approved Program Director who shall be qualified:

- By education and experience in methods, materials, and evaluation of instruction
- And shall have a minimum of one year experience in an administrative or management level position
- And have a minimum of three years academic or clinical experience in prehospital care education within the last five years

Check one and submit documentation verifying one of the following

- ☐ Physician
- ☐ Registered nurse with a baccalaureate degree
- ☐ Paramedic with a baccalaureate degree
- ☐ An individual who holds a baccalaureate degree in a related health field or in education

Experience: Submit a resume including licenses/certificates, job and/or clinical experience and demonstration of your education and experience in methods, materials, and evaluation of instruction.

I certify that I have read and understand the requirements in Title 22, Chapter 4, Article 3, § 100149 regarding the duties of the Course Director and will comply with the requirements as described. I certify that all information on this application, to the best of my knowledge, is true and correct.

Signature: _____ **Date:** _____
(MM/DD/YYYY)

PARAMEDIC TRAINING PROGRAM

PROGRAM MEDICAL DIRECTOR INFORMATION SHEET

Name: _____ _____ _____
Last First MI

Agency: _____

Address: _____ _____ _____ _____
Street City State Zip

Home Phone: _____ **Cell Phone:** _____ **Fax:** _____

E-mail: _____

Qualifications - Each Paramedic Training Program shall have an approved Program Medical Director, licensed in California, who has two years experience in prehospital care in the last five years and who is qualified by education and experience in methods of instruction.

Experience: Submit a resume including licenses/certificates, job and/or medical experience and demonstration of your education and experience in methods, materials, and evaluation of instruction.

I certify that I have read and understand the requirements in Title 22, Chapter 4, Article 3, § Section 100149 regarding the duties of the Program Medical Director and will comply with the requirements as described. I certify that all information on this application, to the best of my knowledge, is true and correct.

Signature: _____ **Date:** _____
(MM/DD/YYYY)

PARAMEDIC TRAINING PROGRAM

PRINCIPAL INSTRUCTOR(s)

Name: _____ _____ _____
Last First MI

Agency: _____

Address: _____ _____ _____ _____
Street City State Zip

Home Phone: _____ **Cell Phone:** _____ **Fax:** _____

E-mail: _____

Qualifications – Principle Instructors must be approved by the Program Director and Medical Director and shall:

- Be qualified by education and experience in methods, materials, and evaluation of instruction
- Have two years experience in ALS prehospital care and be knowledgeable in the course content of the U.S. DOT EMT-P National Standard Curriculum HS 808 862 March 1999)
- Have six years experience in an allied health field or related technology and an associate degree
- Or have two years experience in an allied health field or related technology and a baccalaureate degree

Check one and submit documentation verifying one of the following:

☐ Physician
☐ Registered nurse
☐ Physician assistant
☐ Paramedic – License # _____

Experience: Submit a resume including licenses/certificates, job and/or clinical experience and demonstration of your education and experience in methods, materials, and evaluation of instruction.

I certify that I have read and understand the requirements in Title 22, Chapter 4, Article 3, § 100149 regarding the duties of the Principal Instructor, and will comply with the requirements as described. I certify that all information on this application, to the best of my knowledge, is true and correct.

Signature: _____ **Date:** _____
(MM/DD/YYYY)

(***Make copies for additional Principal Instructors***)

PARAMEDIC TRAINING PROGRAM

TEACHING ASSISTANTS

Name: ______________________ ______________________ ______
Last First MI

Employer: ______________________

Qualifications: EMT -P / RN / Other: ______________________

License Number : ______________ (submit a copy)

Name: ______________________ ______________________ ______
Last First MI

Employer: ______________________

Qualifications: EMT -P / RN / Other: ______________________

License Number : ______________ (submit a copy)

Name: ______________________ ______________________ ______
Last First MI

Employer: ______________________

Qualifications: EMT -P / RN / Other: ______________________

License Number : ______________ (submit a copy)

Name: ______________________ ______________________ ______
Last First MI

Employer: ______________________

Qualifications: EMT -P / RN / Other: ______________________

License Number : ______________ (submit a copy)

Name: ______________________ ______________________ ______
Last First MI

Employer: ______________________

Qualifications: EMT -P / RN / Other: ______________________

License Number : ______________ (submit a copy)

Name: ______________________ ______________________ ______
Last First MI

Employer: ______________________

Qualifications: EMT -P / RN / Other: ______________________

License Number : ______________ (submit a copy)

Duplicate page for additional teaching assistants

Please return this application to:

Kreig Harmon, Paramedic
Prehospital Care Coordinator
Alameda County EMS
1000 San Leandro Blvd., 2nd floor
San Leandro, CA 94577
(510) 667-7984