



COMPLETION OF FIELD INTERNSHIP VERIFICATION

(To be completed by the Medical Director)

I hereby attest that _____ has successfully completed the field internship requirements in accordance with the **“District Procedure for Provisional Licensure”**.

Training Center _____

Class Approval Number _____

I also verify that documentation will be kept on file at the training center for purposes of review at a later date by the Southern Nevada Health District Office of EMS & Trauma System.

Medical Director: _____
(Type or print)

(Signature)

(Today's date)

Please return form to: ems@snhd.org