COMPLETION OF TRAINING VERIFICATION
EMT / AEMT

(To be completed by the Medical Director)

Student's Name _____ _____
(First) (Last)

Date of Birth _____ Last 4 digits of SSN _____

Training Center _____

Class Approval Number _____ Level ☐ EMT ☐ AEMT

The abovementioned student has completed the didactic and lab portions of initial EMS training. During those portions the student has demonstrated knowledge in the areas usually reinforced through clinical rotation. I attest that the student has significantly completed training in lieu of clinical time that is not currently available.

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