

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
EMERGENCY MEDICAL SYSTEMS

EMS #: _____

NREMT# _____

EMS COURSE COMPLETION REPORT

Type of Course (Check one)

Course Number: _____ Course completion date: _____

Course Coordinator: _____ Sponsoring physician: _____

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> FR to EMR Transition | <input type="checkbox"/> Emergency Medical Responder | <input type="checkbox"/> EMT | <input type="checkbox"/> EMT-B to EMT Transition |
| <input type="checkbox"/> AEMT | <input type="checkbox"/> I-85 to AEMT Transition | <input type="checkbox"/> Paramedic | <input type="checkbox"/> Paramedic Transition |
| <input type="checkbox"/> EMS Instructor | <input type="checkbox"/> Immunization | <input type="checkbox"/> Paramedic Transition | |

Applicant Information (Please print)

Name: _____
(Last) (First) (Middle)

Mailing Address _____
(Street / P.O. Box) (City) (County) (State) (Zip)

DOB: _____ SS#: _____

Phone # : _____ / _____
(Home) (Work) Male Female

Employment Address: _____
(Street) (City) (State) (Zip)

I / We certify that the above person has successfully completed the above noted EMS course.

Signed: _____ Date: _____
Course physician of record with license number (Sign in **BLUE** ink)

Signed: _____ Date: _____
EMS course coordinator (Sign in **BLUE** ink)

Course Completion Date: _____ Final Written Evaluation: Pass / Fail Final Practical Evaluation: Pass / Fail
(Circle One) (Circle One)

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
EMERGENCY MEDICAL SYSTEMS
4150 Technology Way, Suite 101
Carson City, NV 89706
(775) 687-7590
EMSTraining@health.nv.gov