

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**  
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