

State of Nevada  
Division of Public and Behavioral Health  
**Emergency Medical Systems Program**  
1020 Ruby Vista Dr, Suite 103, Elko, NV 89801

**RENEWAL APPROVAL OF AN EMS COURSE**

Please review the information listed below. If no changes have occurred since the last course submission, or eighteen (18) months please check the 'No Change' box in the left-hand column. If there were changes, please mark the 'Changes' column and attach the updated document(s) and complete the "Changes" box on this form. Please reference prior course approval number.

Once you have completed your review of all required documentation, the agency EMS Coordinator and the agency Medical Director must sign the bottom of this form attesting to the accuracy of the information provided. Please submit a minimum of twenty (20) business days in advance to the Elko Office. If you have any questions about any of the required documentation, or changes, please contact Nevada State EMS Program Education Coordinator.

Prior Course Approval Number: \_\_\_\_\_

Name of Course/ Date/ Location of course: \_\_\_\_\_

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<b>Checklist</b>		
<b>No Changes</b>	<b>Changes Made</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Course Curriculum
<input type="checkbox"/>	<input type="checkbox"/>	Textbook
<input type="checkbox"/>	<input type="checkbox"/>	List of Instructors
<input type="checkbox"/>	<input type="checkbox"/>	Agency Coordinator
<input type="checkbox"/>	<input type="checkbox"/>	Medical Director
<input type="checkbox"/>	<input type="checkbox"/>	Clinical Rotations
<input type="checkbox"/>	<input type="checkbox"/>	Ride-A-Long Rotations

**Changes:**

By signing below, you are attesting that all the above information, if not changed, is currently on file with the Nevada State EMS Program. Please make sure you have all this information on file for Site Audit Review when requested. Course records are to be retained for a minimum of 5 years.

\_\_\_\_\_  
EMS Coordinator (printed name)                      Date

\_\_\_\_\_  
Medical Director (printed name)                      Date

\_\_\_\_\_  
EMS Coordinator (signature)

\_\_\_\_\_  
Medical Director (signature)

Thank you for your cooperation in processing your renewal of course approval. Please send this completed form along with any necessary documentation, scanned in color to: [bsullivan@health.nv.gov](mailto:bsullivan@health.nv.gov)