Instructions: The agency training officer or designee complete the entire form once the applicant has successfully demonstrated competency in each section. Only complete the sections that are required for the applicants level of care.

____ Applicant Name

________________________________ Date

EMR/BLS Medications							
Medication	**EMR**	**BLS**		**Indication**	**Contra**	**Dose**	**Administration**
Albuterol		X		□	□	□	□
Aspirin	X	X		□	□	□	□
Atrovent		X		□	□	□	□
Diphenhydramine		X		□	□	□	□
Epinephrine(IM/Auto-Injector)		X		□	□	□	□
Glucagon		X		□	□	□	□
Ibuprofen		X		□	□	□	□
Narcan	X	X		□	□	□	□
Nitroglycerin		X		□	□	□	□
Oral Glucose	X	X		□	□	□	□
Ondasetron		X		□	□	□	□

EMR/BLS Skills						
Skill	**EMR**	**BLS**		**Indication**	**Contra.**	**Administration**
BIAD	X	X		□	□	□
CPAP		X		□	□	□
Defibrillator	X	X		□	□	□
Quikclot	X	X		□	□	□
Glucometer	X	X		□	□	□
12-Lead*		X		□	□	□
Wound Packing	X	X		□	□	□

* For agencies equiped with 12-lead capabilities

____ Training Officer Name Printed

____ Training Officer Signature