WREMAC
Western Regional Emergency Medical Advisory Committee
ALLEGANY, CATTARAUGUS, CHAUTAUQUA, ERIE,
GENESEE, NIAGARA, ORLEANS, AND WYOMING COUNTIES

CFR and EMT

Mandatory Annual Skills Summary Form

Name: _____ Date: _____

Certification #: _____ CPR Expiration: _____

Certification Expiration: _____ Agency Medical Director: _____

Primary EMS Agency: _____

Certified First Responder Skills Evaluation

				Circle Method Used to Demostrate Skill (See options below)
AED	Date: _____	Evaluator:	_____	**1 2 3**
BLS Naloxone *	Date: _____	Evaluator:	_____	**1 2 3**

EMT Skills Evaluation

AED	Date: _____	Evaluator:	_____	**1 2 3**
BLS Naloxone *	Date: _____	Evaluator:	_____	**1 2 3**
Nebulized Albuterol*	Date: _____	Evaluator:	_____	**1 2 3**
Blood Glucose Monitoring*	Date: _____	Evaluator:	_____	**1 2 3**
Epi-Pen*	Date: _____	Evaluator:	_____	**1 2 3**

*** Demonstrated only if agency is approved to use the skill**

Annual Skills Verification (Evaluator): _____ _____
Print Signature

CFR/EMT Signature: _____

Skill competency shall be demonstrated to the medical director (or his designee), as follows:

1. Demonstrate the skill in simulation to the medical director (or designee); or
2. Documented successful performance of the skill during patient care; or
3. Attend medical director (or designee) approved training on the skill.

A copy of this summary must be maintained in each providers agency file.

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EMT - I

Mandatory Annual Skills Summary Form

Name: _____ Date: _____

Certification #: Certification _____ CPR Expiration: _____

Expiration: Primary EMS _____ TLS Expiration: _____

Agency: _____

Agency Medical Director: _____

				Circle Method Used to Demostrate Skill (See options below)		
AED	Date: _____	Evaluator:	_____			
Epi-Pen*	Date: _____	Evaluator:	_____	**1**	**2**	**3**
Nebulized Albuterol *	Date: _____	Evaluator:	_____	**1**	**2**	**3**
BLS Naloxone *	Date: _____	Evaluator:	_____	**1**	**2**	**3**
Blood Glucose Monitoring*	Date: _____	Evaluator:	_____	**1**	**2**	**3**
IV (adult & pediatric)	Date: _____	Evaluator:	_____	**1**	**2**	**3**
Saline Trap	Date: _____	Evaluator:	_____	**1**	**2**	**3**
IO (adult & pediatric)*	Date: _____	Evaluator:	_____	**1**	**2**	**3**
EJ Cannulation*	Date: _____	Evaluator:	_____	**1**	**2**	**3**
ET Intubation (adult)*	Date: _____	Evaluator:	_____	**1**	**2**	**3**
ET Intubation (pediatric)*	Date: _____	Evaluator:	_____	**1**	**2**	**3**
Rescue Airways (Kings, etc)	Date: _____	Evaluator:	_____	**1**	**2**	**3**
CPAP*	Date: _____	Evaluator:	_____	**1**	**2**	**3**
Needle Thoracostomy*	Date: _____	Evaluator:	_____	**1**	**2**	**3**

* **Demonstrated only if agency is credentialed to use the skill**

Annual Skills Verification (Evaluator): _____ _____

Print Signature

EMT - I Signature: _____

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AEMT

Mandatory Annual Skills Evaluation Form

Name: _____ Date: _____

Certification #: _____ CPR Expiration: _____

Certification Expiration: _____ TLS Expiration: _____

Primary EMS Agency: _____ PLS Expiration: _____

Agency Medical Director: _____ ACLS Expiration: _____

					Circle Method Used to Demostrate Skill (See options below)		
AED	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Epi-Pen	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Nebulized Albuterol	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Blood Glucose Monitoring	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
IV (adult & pediatric)	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Saline Trap	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
IO (adult & pediatric)*	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
EJ Cannulation*	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
ET Intubation (adult)*	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
ET Intubation (pediatric)*	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Rescue Airways (Kings, etc)	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
CPAP*	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Needle Thoracostomy*	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
IV Bolus Medication	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Subcutaneous/IM injection	Date:	_____	Evaluator:	_____	**1**	**2**	**3**

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Annual Skills Verification (Evaluator): _____ _____

Print Signature

AEMT Signature: _____

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EMT - CC

Mandatory Annual Skills Evaluation Form

Name: _____ Date: _____

Certification #: _____ CPR Expiration: _____

Certification Expiration: _____ TLS Expiration: _____

Primary EMS Agency: _____ PLS Expiration: _____

Agency Medical Director: _____ ACLS Expiration: _____

					Circle Method Used to Demostrate Skill (See options below)		
Nebulized Medication	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Blood Glucose Monitoring	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
IV (adult & pediatric)	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Saline Trap	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
IO (adult & pediatric)	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
EJ Cannulation	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
ET Intubation (adult)	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
ET Intubation (pediatric)	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Rescue Airways (Kings, etc)	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
CPAP*	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Manual Defibrillation	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Lead II cardiac Monitoring	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
12-lead monitoring	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Synchronized cardioversion	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
External Pacing	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
NG/OG Tube	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Needle Thoracostomy	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Needle Cricothyrotomy	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
IV Bolus Medication	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Subcutaneous/IM injection	Date:	_____	Evaluator:	_____	**1**	**2**	**3**

*** Demonstrated only if agency is credentialed to use the skill**

Annual Skills Verification (Evaluator): _____ _____

Print Signature

EMT - CC Signature: _____

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EMT - P

Mandatory Annual Skills Evaluation Form

Name: _____ Date: _____

Certification #: _____ CPR Expiration: _____

Certification Expiration: _____ TLS Expiration: _____

Primary EMS Agency: _____ PLS Expiration: _____

Agency Medical Director: _____ ACLS Expiration: _____

					Circle Method Used to Demostrate Skill (See options below)		
Nebulized Medication	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Blood Glucose Monitoring	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
IV (adult & pediatric)	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Saline Trap	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
IO (adult & pediatric)	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
EJ Cannulation	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
ET Intubation (adult)	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
ET Intubation (pediatric)	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Rescue Airways (Kings, etc)	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
CPAP*	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Manual Defibrillation	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Lead II cardiac monitoring	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
12-lead monitoring	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Synchronized cardioversion	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
External Pacing	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
NG/OG Tube	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Needle Thoracostomy	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Needle Cricothyrotomy	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
IV Bolus Medication	Date:	_____	Evaluator:	_____	**1**	**2**	**3**
Subcutaneous/IM injection	Date:	_____	Evaluator:	_____	**1**	**2**	**3**

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Print Signature

EMT - P Signature: _____

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