TEACHING ASSISTANT INFORMATION

INSTITUTION: _____

ADDRESS: _____

_____

TELEPHONE: ( ) _____ EXT. _____

TEACHING ASSISTANT _____

ADDRESS: _____

_____

TELEPHONE: HOME ( ) _____ WORK ( ) _____

ELIGIBILITY STATUS	LICENSE OR CERT. NO.	EXP. DATE
☐ Physician licensed in the State of California		
☐ Registered Nurse licensed in the State of California		
☐ Physician's Assistant certified in the State of California		
☐ EMT-P licensed in the State of California		
☐ EMT-I certified in the State of California		

COURSES/SKILLS LABS TO BE TAUGHT BY THIS INSTRUCTOR:

☐ EMT-I Training Course ☐ EMT-P Training Course ☐ Other

☐ EMT-I Refresher Course ☐ EMT-P Refresher Course _____

☐ EMT-I Transition Course ☐ MICN Course

APPROVED BY: _____

Name of EMS Program Director

_____

Signature

_____

Date

A photocopy of all pertinent licenses and a resume, including all EMS work experiences, must be attached.

EMS AGENCY REVIEW

APPROVED

☐ YES

☐ NO

_____

Signature

_____

Title

_____

Date