



PHYSICIAN ADVISOR VERIFICATION OF EMS REGISTERED NURSE SKILLS
(Please Type or Print)

NAME: _____ RN LICENSE # _____ EXP. DATE: _____

MAILING ADDRESS: _____
Street City State Zip

PHONE: Home () Work () _____

PERMITTEE: _____ SOC. SEC. # _____ D.O.B. _____

ADDRESS: _____

A. Mark those skills for which proof of training can be provided and for which physician authorization is given as allowed under NAC 632.225.

- | | |
|---------------------------------|---|
| 1. () Orotracheal Intubation | 7. () Needle Thoracentesis |
| 2. () Nasotracheal Intubation | 8. () Tube Thoracostomy |
| 3. () Esophageal Intubation | 9. () MAST/PASG |
| 4. () Peripheral Venous Lines | 10. () External Pacing |
| 5. () Central Venous Lines | 11. () Intraosseous Infusion |
| Identify Line: _____ | 12. () Pericardiocentesis |
| 6. () Needle Cricothyroidotomy | 13. () Other EMS Nursing/PA Procedures |
| | Beyond Basic Nursing Education |
| | (List on Separate Page) |

B. Mark any specialty training courses which you have completed and provided copies of any certificates awarded.

- | | |
|---------------------|--------------------------------------|
| 1. () CCRN | 5. () PALS / PEPP |
| 2. () ENP | 6. () PHTLS |
| 3. () Flight Nurse | 7. () Extrication |
| 4. () ACLS | 8. () Other (List on separate page) |

CERTIFICATION: I hereby certify that all entries made on this form are true. I understand that the documentation may be audited and that any false statement may cause the Health District to request the State Board of Nursing to undertake an official investigation of my records. A copy of my letter of approval from the State Board of Nursing is attached.

SIGNATURE _____ DATE: _____

EMS RN

PHYSICIAN ADVISOR VERIFICATION: I hereby verify that I have authorized the EMS Registered Nurse named above to perform those procedures identified above in accordance with written policies/protocols which I have issued. A copy of those protocols is attached.

SIGNATURE _____ DATE _____

EMPLOYER VERIFICATION: We hereby verify that the above information is accurate and the above named EMS Registered Nurse is employed or a volunteer member of our agency and is functioning in accordance with the written policies/protocols of the Physician Advisor named above.

Nursing Supervisor: _____
(Type or Print)

Signature Date

Ambulance Operator: _____
(Type or Print)

Signature Date