Southern Nevada Health District

PHYSICIAN ADVISOR VERIFICATION OF CRITICAL CARE PARAMEDIC SKILLS

(Please Type or Print)

NAME:_____ EMS # _____ EXP. DATE: _____

MAILING ADDRESS:_____
Street City State Zip

PHONE: Home (_____) Work (_____)

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

ADDRESS:_____

Mark those skills for which proof of training can be provided and for which physician authorization is given.

1. ( ) Orotracheal Intubation
2. ( ) Nasotracheal Intubation
3. ( ) Esophageal Intubation
4. ( ) Peripheral Venous Lines
5. ( ) Central Venous Lines
   Identify Line: _____
6. ( ) Needle Cricothyroidotomy
7. ( ) Needle Thoracentesis
8. ( ) Tube Thoracostomy
9. ( ) MAST/PASG
10. ( ) External Pacing
11. ( ) Intraosseous Infusion
12. ( ) Pericardiocentesis
13. ( ) Other Critical Care Paramedic Procedures (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 undertake an official investigation of my records.

SIGNATURE_____ DATE:_____

PHYSICIAN ADVISOR VERIFICATION: I hereby verify that I have authorized the Critical Care Paramedic named above to perform those procedures identified above in accordance with written policies/protocols which I have issued.

SIGNATURE_____ DATE_____