WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH
OFFICE OF EMERGENCY MEDICAL SERVICES
350 CAPITOL STREET, ROOM 515
CHARLESTON, WEST VIRGINIA 25301-3716

TWO-YEAR EMT-P RECERTIFICATION
PRACTICAL EVALUATION PERFORMANCE FORM

Name of EMT-P: _____ Squad: _____

Certification Number: _____ Expiration Date: _____

Squad Medical Director: _____

Note: Squad Medical Directors must initial and date in the appropriate columns. Verification may be completed based on field experience, in-squad practical skill stations, or skill station evaluations at an ACLS or similar formal course.

SKILLS/TECHNIQUES	YEAR ONE		YEAR TWO		COMMENTS
	INITIALS	DATE	INITIALS	DATE	
Airway Management/Intubation					
Chest Decompression *					
Defibrillation/Pacing					
EKG Interpretation					
Intraosseous Infusion *					
Intravenous Therapy					
Needle Cricothyroidotomy *					
Patient Assessment					
BLS Skills I					
BLS Skills II					

* if permitted by Regional Protocol

I hereby warrant the above named Paramedic has been evaluated in the above listed practical skills and is competent to perform the skills in the field.

_____ _____
Squad Medical Director Approval Date Squad Training Officer Date

_____ _____
EMT-Paramedic Date Regional Medical Director Review Date