DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA
Health Emergency Preparedness and Response Administration

Student Skill Verification Form
EMR Certification Programs

Training Center Name: _____

Class # / Course Cohort: _____

Student Name: _____

As the program director (or designee) of this educational institute, I hereby attest that the aforementioned student has successfully completed all required EMR skills listed below.

Inserting an OPA	Ventilating a patient with a BVM	O2 administration via Nasal Cannula
O2 Administration via NRB	Airway Suctioning	Cardio-Pulmonary Resuscitation
Using a commercial tourniquet	Wound Packing	Applying a cervical collar
Manual cervical stablilzation	Extremity splinting	Emergency patient moves
Auto-Injector Medications	Intranasal Medications	Assisted Delivery - Childbirth
Blood Pressure by Auscultation	Blood Pressure by Palpation	Assessment of Vital Signs
Eye Irrigation	Medical Assessment	Trauma Assessment

Program Director (Signature): _____ Date: _____