



**Student Skill Verification Form  
 EMT 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 EMT skills listed below.

Performing a Power Lift	Using an Orthopedic Scoop	Carrying a patient up/downstairs
Using a stairchair	Loading a stretcher into the ambulance	Direct ground lift
Blood Pressure by Auscultation	Blood Pressure by Palpation	Obtaining Vital Signs
Measuring Pulse Oximetry	Blood Glucometry	Neurovascular Assessment
Medical Assess - Conscious	Trauma Assess- Conscious	Pt. Assess - Unconscious
OPA Insertion	NPA Insertion	Suctioning the Airway
Assembling an O2 Cylinder	Using a non rebreather mask	Mouth to mask ventilation
One Rescuer BVM Ventilation	Two Rescuer BVM Ventilation	CPAP
Epipen Administration	MDI Administration	ASA Administration
Naloxone Administration	Shock Management	Adult/Child Cardiac Arrest
Infant Cardiac Arrest	Stroke Assessment	Tourniquet Application
Controlling Epistaxis	Impaled Object Management	Cervical Collar Application
Immobilization to long spine board	Immobilization via a KED	Sucking Chest Wound
Flail Chest Management	Abdominal Evisceration	Rigid Splint Application
Traction Splint Application	Amputation Management	Pediatric Airway Management
Rapid Extrication Technique	12 lead EKG application	Eye Irrigation

Program Director (Signature): \_\_\_\_\_ Date: \_\_\_\_\_