



## General Instructions

- All applications must be submitted by the sponsoring EMS Educational Institution's Program Coordinator or Medical Director, not individual instructors.
- To ensure timely processing of the application, please make sure that all of the required documents are attached when they are sent the Department of Health.
- The EMS Educational Institution's Program Coordinator and Medical Director must sign the application.

## Curriculum Documentation

- The curriculum must include each course topic.
  - If it is anticipated that the curriculum will be used for continuing education, include the number of hours in each topic.
- A copy of the curriculum must be included with this application.
- Indicate if this curriculum is part of a pilot program.

## Approval

- This form needs to be submitted to the Department of Health at least 45 days prior to the proposed start date to use the curriculum to allow the application to be processed before the start date of the course.
- CE curricula approved by CECBEMS need to be submitted to DOH to obtain a curriculum tracking number.
- A curriculum may not be used until it is approved by the Department of Health and assigned a curriculum tracking number and approved for use.
- A curriculum tracking number will be included in the curriculum authorization letter upon approval. Please keep this number for your records and use on all curriculum correspondence.



Government of the District of Columbia – Department of Health  
**EMS Curriculum Approval Application**



**Educational Institution Information**

Sponsoring Educational Institution: \_\_\_\_\_ Number: \_\_\_\_\_  
 Lead Author: \_\_\_\_\_ Number: \_\_\_\_\_  
 Program Coordinator: \_\_\_\_\_ Number: \_\_\_\_\_  
 Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_  
 E-Mail: \_\_\_\_\_

**Curriculum Information**

Curriculum Title: \_\_\_\_\_ Total Hours: \_\_\_\_\_

Identify which of the following topic area(s) are covered by the curriculum, and how many hours for each topic.

Basic Life Support	Hours
<input type="checkbox"/> Preparatory	
<input type="checkbox"/> Airway & Breathing	
<input type="checkbox"/> Patient Assessment	
<input type="checkbox"/> Medical/ Behavioral	
<input type="checkbox"/> Trauma	
<input type="checkbox"/> Infants & Children	
<input type="checkbox"/> Obstetrics	

Advanced Life Support	Hours
<input type="checkbox"/> Operational Tasks	
<input type="checkbox"/> Airway & Breathing	
<input type="checkbox"/> Cardiology	
<input type="checkbox"/> Medical Emergencies	
<input type="checkbox"/> Trauma	
<input type="checkbox"/> Pediatrics	
<input type="checkbox"/> Obstetrics	

*Attach a Copy of the Curriculum to This Application*

Pilot Program

**Certification**

I hereby certify that the information contained within this application is true and complete to the best of my knowledge and belief. I understand and acknowledge that the making of a false statement in connection with this application is punishable by criminal penalties, and may also subject me to civil penalties and to the denial, termination or revocation of the authorization to use the curriculum.

\_\_\_\_\_  
*Signature of the Program Coordinator*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of the Medical Director*

\_\_\_\_\_  
*Date*