STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH
OFFICE OF EMERGENCY MEDICAL SERVICES

Application to conduct an AEMT Training Program

e. dph.emsi@ct.gov | p. 860-509-7975 | f. 860-920-3142 | www.ct.gov/dph/ems

INSTRUCTIONS:

1. Complete this application. (fields outlined in red are required.)
2. Print a copy for your records by clicking the "**print form**" button at the bottom of this form.
3. Submit to OEMS by clicking the "**submit form**" button at the bottom of this form, which will open a new email window.
   NOTE: Please ***do not*** edit what is auto-generated in the subject line of the submission email.

Program Information

Program Director

First Name | MI | Last Name

Mailing address | City | State | Zip Code

Email address | Primary phone number | Secondary phone number

Program Location

Course Name | **Course Location** include building/room # if applicable)

Mailing address | City | State | Zip Code

Sponsoring Agency (if different from Course Location)

Start date of course | End date of course

Is this course open to the public? ○ Yes ○ No

Meetings days & times:

☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat. ☐ Sun.

Note: the Office of Emergency Medical Services will randomly review the syllabus submitted with this application for adherence to the 2009 National AEMT Education Guidelines. It is incumbent upon the Program Director and the Physician Medical Director to ensure that the standards are met.

Additionally, OEMS may perform random audits of the program's lesson plans, attendance rosters, clinical competency forms, skills tracking forms, or any other course–related documentation, for purposes of compliance, quality assurance and/or investigation..

Click to print form

CT DPH, EMS Application Processing
410 Capitol Ave., MS# 12EMS
PO Box 340308
Hartford, CT 06134-0308

Click to submit

Clinical/Field Site Information

List all clinical sites, including hospitals, field ridership/preceptor sites at which students will perform clinical skills: (you must attach [behind this page] copies of current, dated, signed agreements with each of the below listed sites).

Clinical/Field Sites	Contact Person	E-Mail address	Phone Number

AEMT Program Instructor Roster

Lead Instructor:

First Name | MI | Last Name

Mailing address | City | State | Zip Code

Email address | Primary phone number | Secondary phone number

Assistant Instructors:

First Name | MI | Last Name

Mailing address | City | State | Zip Code

Email address | Primary phone number | Secondary phone number

First Name | MI | Last Name

Mailing address | City | State | Zip Code

Email address | Primary phone number | Secondary phone number

First Name | MI | Last Name

Mailing address | City | State | Zip Code

Email address | Primary phone number | Secondary phone number

First Name | MI | Last Name

Mailing address | City | State | Zip Code

Email address | Primary phone number | Secondary phone number

Required Attachments Checklist

This application will not be considered for approval unless all of the required attachments are included. Incomplete applications will be returned to the applicant.

- ☐ Curriculum Vitae of Program Medical Director
- ☐ Curriculum Vitae of Program Director
- ☐ Curriculum Vitae of Lead Instructor
- ☐ Signed agreements with all clinical rotation sites and field preceptor services
- ☐ Certificate(s) of insurance which demonstrates that medical/professional liability insurance is in force for all students and faculty
- ☐ List of all assistant faculty/instructors who are affiliated with the course to include title and credentials
- ☐ Course syllabus to include:
  - -date/time/location of each class
  - -topic/subject for each class
  - -tentative faculty assignment for each class
  - -program procedures & policies
- ☐ Class calendar to include instructor name responsible for the teaching of each class/lab session

Program Director Statement

I certify that I, the Course Program Director, have completed and submitted all pages of this application to Conduct AEMT Training, and that this application, and all attachments, represents a true and accurate record of the training program to be conducted. I certify and attest that this course meets, both in form and content, the 2009 National EMS Education Standards and 2007 Scope of Practice Model for the Advanced Emergency Medical Technician. I further attest that the conduct of the course described herein will adhere in form and content to all applicable Connecticut Department of Public Health Regulations and Connecticut General Statutes.

As the Program Director, I will routinely review each student's performance to assure adequate progress toward completion of the program, and will attest that each graduating student has achieved the required level of competence as delineated in the 2009 National EMS Education Standards and 2007 Scope of Practice Model of the Advanced Emergency Medical Technician, prior to graduation.

Program Director Name (printed)

Program Director (signature)

Date

Physician Medical Director Statement

I certify that I, the Advanced Emergency Medical Technician (AEMT) Program Medical Director, am currently and actively affiliated with the Sponsor Hospital for the AEMT Training Program. I am a sponsor hospital emergency department physician with experience and current knowledge of emergency care of acutely ill and traumatized patients. I am also knowledgeable about the 2009 National EMS Education Standards and 2007 Scope of Practice Model for the AEMT, and the provision of base station on-line medical direction.

As part of my duties as Program Medical Director, I certify that I will review and approve the educational content of the program curriculum and the quality of the medical instruction and supervision delivered by the faculty. I will routinely review each student's performance to assure adequate progress toward completion of the program and will attest that each graduating student has achieved the required level of competence as delineated in the 2009 National EMS Education Standards and 2007 Scope of Practice Model for the AEMT prior to graduation.

Program Medical Director Name (printed)

Program Medical Director (signature)

Date