



**STATE OF CONNECTICUT**  
**DEPARTMENT OF PUBLIC HEALTH**  
 Office of Emergency Medical Services



**PARAMEDIC LICENSURE**  
**VERIFICATION OF PARAMEDIC TRAINING PROGRAM**

\*For all fields to work properly, please download form to computer and open with Adobe Acrobat

**TO BE COMPLETED BY EDUCATIONAL INSTITUTION ONLY**

This is to certify that the below mentioned individual satisfactorily complete an approved training program adhering to the most current EMS Education Guidelines as promulgated by the US Department of Transportation at \_\_\_\_\_

**Student's Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **MI:** \_\_\_\_ **Maiden Name:** \_\_\_\_\_

Date course of training completed: \_\_\_\_\_

Dates of individual's attendance: From \_\_\_\_\_ To \_\_\_\_\_

Course Approval Number: \_\_\_\_\_

Total numbers of hours completed at the Paramedic Course: \_\_\_\_\_

**I understand that that this information is subject to review upon request by the Department of Public Health and that all of the statements contained herein are true and correct to the best of my knowledge and belief.**

Name of Course Coordinator: \_\_\_\_\_

Signature of Course Coordinator: \_\_\_\_\_ Title: \_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Date: \_\_\_\_\_

Course coordinator only, please complete and return via email to [dph.emslicensing@ct.gov](mailto:dph.emslicensing@ct.gov) (click to Submit button) (*preferred method*) via fax at 860-920-3142 or via mail to:

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