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 Acobat

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:_____

SSN#: _____ DOB:_____ 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 (click to Submit button) (*preferred method*) via fax at 860-920-3142 or via mail to:

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