EMT BASIC SCOPE OF PRACTICE APPROVED ELECTIVE SKILLS

SERVICE PROVIDER APPLICATION

Service Provider				
Administrator				
Administrator Email Address				
Mailing Address (including City and Zip Code)				
Phone #	Fax #	Approved AED Provider: □ YES □ NO		
Elective Skills Applying For	Epi Auto-Injector ☐	IN naloxone ☐	CPAP ☐	Blood Glucose Testing ☐
Proposed Target Date for Elective Skills Implementation:		Estimate # of personnel to certify on Elective Skills:		
Program Coordinator:		Program Coordinator Email Address:		
Primary Instructor(s)		Primary Instructor(s) Email Address		

Attach the following:	ENCLOSED	APPROVED (EMSA use only)
1. Letter of Intent		
2. Description of need for Elective Skill(s)		
3. Training program outline		
4. Procedure for ongoing quality improvement activities		

I agree to comply with all State and local regulations including the County of San Luis Obispo EMS Agency Policy 215, EMT Basic Scope of Practice Approved Elective Skills Requirements for EMS Provider Agencies

Administrator's Signature	**Date**

EMS Agency Use Only

Date App. Rec'd	Reviewed By	Letter of Receipt Sent	Date and Signature of Approval	Date Approval Letter Sent	CE Provider Number (if applicable)

Submit this document with attachments to: County of San Luis Obispo EMS Agency, 2180 Johnson Ave., 2nd Floor San Luis Obispo, CA
Office: (805) 788-2514 Fax: (805) 788-2517