

**EMT OPTIONAL SKILLS APPLICATION**

<b>APPLICANT INFORMATION</b>	
EMS Provider Agency Name:	
EMS Provider Agency Address:	Liaison's Name:
Liaison's Phone Number:	Liaison's Email:

<b>EMT OPTIONAL SKILLS APPLYING FOR:</b>	
<input type="checkbox"/> Use of perilyngeal airway adjuncts. <input type="checkbox"/> Administration of epinephrine by prefilled syringe and/or drawing up the proper drug dose into a syringe for suspected anaphylaxis and/or severe asthma. Administer the medications: <input type="checkbox"/> Atropine and/or <input type="checkbox"/> Pralidoxime Chloride. <input type="checkbox"/> Monitor preexisting vascular access devices and intravenous lines delivering fluids with additional medications pre-approved by the Director of the Authority.	

<b>SUBMIT THE FOLLOWING WITH THIS APPLICATION:</b>	
<input type="checkbox"/> Letter of intent. <input type="checkbox"/> Identify an EMT Optional Skills Liaison. <input type="checkbox"/> Identify primary instructor(s) and verify eligibility. <input type="checkbox"/> Copy of all training materials, including presentations, handouts, written exams, and descriptions of skill demonstrations that verify competency in each skill. <input type="checkbox"/> A description of the plans for initial training and competency verification for authorized EMTs. <input type="checkbox"/> Copy of the EMSQIP and written procedure for ongoing activities specific to the use of EMT Optional Skills. <input type="checkbox"/> Pay non-refundable fee.	

<b>ATTESTATION OF EMT OPTIONAL SKILLS APPLICANT</b>	
I hereby certify that I have reviewed and understand the County of San Luis Obispo EMS Policy #224, EMT Optional Skills Authorization and Title 22, Div. 9 requirements.	
Applicant's Name:	Applicant's Title:
Signature: _____ Date: _____	

<b>*****EMS AGENCY USE ONLY BELOW THIS LINE*****</b>	
Received Date:	<input type="checkbox"/> Email confirmation of application received.
Response Date (w/in 21 work days):	<input type="checkbox"/> Letter on file.