TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATIONS
OFFICE OF EMERGENCY MEDICAL SERVICES
665 MAINSTREAM DRIVE, 2ND FLOOR
NASHVILLE, TN 37243

VERIFICATION OF INITIAL CLINICAL TRAINING

Training Institution: _____ **Class #:** _____ **DATE:** _____

Student Name: _____ **SSN#:** _____
Print or type

The above named individual has completed and has on file the following documentation:

1. ☐ Completion of _____ hours in Clinical Rotations.
2. ☐ Required minimum of ten (10) patient contacts.

   Balance of Contacts was:

   _____ Live Patient Contacts _____ Simulated Patient Contacts
3. ☐ The required attendance hours and successful completion of the course.

(Individual patient assessment forms are on file at the sponsoring training institution.)

I hereby verify that the information above is correct and that all verification is on file with the training institution listed above.

_____ _____
Student Signature **Date**

_____ _____
Instructor/Coordinator Signature **Date**

I have seen verification of the information listed above:

_____ _____
Regional EMS Consultant Signature **Date**