



TENNESSEE DEPARTMENT OF HEALTH  
OFFICE OF EMERGENCY MEDICAL SERVICES

**ADVANCED EMERGENCY MEDICAL TECHNICIAN  
COURSE SKILLS EVALUATION**

Student Name: \_\_\_\_\_ Class Number: \_\_\_\_\_

Instructor/Course Coordinator: \_\_\_\_\_ School Name: \_\_\_\_\_

SKILL	I/C INITIAL	DATE	PASS
<b>AIRWAY MANAGEMENT</b>			
Oxygen Tank Set-Up and Administration			
Ventilation Skills – BVM and Pocket Mask			
Demand Valve (manually triggered ventilation)			
Oro / Nasopharyngeal Airways and Suctioning			
Airways not intended for Trachea			
Pulse Oximetry			
Inhaler			
Nebulizer			
<b>PATIENT ASSESSMENT / MANAGEMENT</b>			
Medical Assessment			
Trauma Assessment			
<b>BLEEDING CONTROL</b>			
Direct Pressure			
Tourniquet			
<b>BANDAGING</b>			
Amputation			
Eye Irrigation and Bandaging			
Head Bandage			
Impaled Objects			
<b>SPLINTING</b>			
Board Immobilization – Hip			
Board Immobilization - Radius / Ulna			
Board Immobilization – Tibia / Fibula			
Flail Chest			
Foot / Ankle Injury			
Joint Injury Management			
PASG – Splint			
Sling and Swathe			
Traction Splint			
<b>PACKAGING</b>			
Clam Shell Device			
Long Spine Board			

MISCELLANEOUS			
Cardiac Arrest Management (CPR / AED)			
Glucometers			
Auto Injectors			
IM Injection			
Sub Q Injection			
Intranasal			
Intravenous Initiation Peripheral			
Intravenous Maintenance of Non-Medicated IV			
Pediatric Intraosseous Initiation			
MEDICATIONS			
Glucagon			
Oral Glucose			
D50/D25			
Nitroglycerin			
ASA			
Nitrous Oxide			
Narcan			
Epinephrine			

**I verify that I have completed all of the above skills through theory and have obtained competency.**

\_\_\_\_\_  
Student's Name (Print or Type)

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date

**I confirm that the above named student has successfully completed all didactic, laboratory, clinical and field internship as outlined in the National DOT AEMT Educational Standards. The student has completed through theory and obtain competency of all skills listed in this document. The student has also met all attendance requirements outlined in the program syllabus.**

\_\_\_\_\_  
Instructor Coordinator Name (Print or Type)

\_\_\_\_\_  
Instructor Coordinator Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Medical Director's Name (Print or Type)

\_\_\_\_\_  
Medical Director's Signature

\_\_\_\_\_  
Date