TN Department of Health

VERIFICATION OF TRAINING

Program Name (Please choose one): ☐ Critical Care Paramedic ☐ Community Paramedic

This is to verify that

_____

STUDENT NAME

has successfully completed all course objectives and demonstrated proficiency and competency in all areas of the board approved program indicated above.

_____

EDUCATIONAL PROGRAM

_____	_____
Course Approval Number	Date
_____	_____
Program Director (Print Name)	Program Director (Signature)
_____	_____
Medical Director (Print Name)	Medical Director (Signature)

Division of Health License and Regulations • **Office of Emergency Medical Services**
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