TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF EMERGENCY MEDICAL SERVICES

EMERGENCY MEDICAL RESPONDER
PRACTICAL SKILLS VERIFICATION

Student Name: _____ **Social Security #:** _____

Training Agency: _____ **Class Number:** _____

SKILL	DATE (mm/dd/yyyy)	SATISFACTORY	INSTRUCTOR INITIALS
PATIENT ASSESSMENT			
Medical		☐	
Trauma		☐	
Documentation		☐	
OXYGEN ADMINISTRATION			
O2 Administration		☐	
AIRWAY ADJUNCTS			
Oral Airways		☐	
Bag-Valve-Mask		☐	
Pocket Mask		☐	
BANDAGING			
Eye Irrigation and Bandage		☐	
Head		☐	
Amputation		☐	
SPLINTING			
Sling and Swathe		☐	
Cervical Immobilization		☐	
Radius/Ulna Board		☐	
Tibia/Fibula Board		☐	
Hip		☐	
Spinal Immobilization		☐	
BLEEDING CONTROL			
Direct Pressure		☐	
Tourniquet		☐	
ASSISTING			
Clam Shell Device		☐	
Scoop Stretcher		☐	
Traction Splinting		☐	
Ambulance Cot Operations		☐	
CARDIAC ARREST MANAGEMENT			
CPR (expiration date _____)		☐	
AED		☐	

This individual has demonstrated knowledge and skill competencies in the above listed procedures and has met all course attendance and completion requirements.

_____ _____

Instructor Printed Name Date Instructor Signature

I acknowledge that I have performed and practiced each of the skills listed above.

_____ _____

Students Printed Name Date Signature of Student