STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
EMERGENCY MEDICAL SYSTEMS

EMS #: ______________

NREMT#______________

EMS COURSE COMPLETION REPORT

Type of Course (Check one)

Course Number:______________________________ Course completion date:______________________________

Course Coordinator:______________________________ Sponsoring physician:______________________________

Type of Course

☐ EMR ☐ EMR Refresher ☐ EMT ☐ EMT Refresher

☐ AEMT ☐ AEMT Refresher ☐ Paramedic ☐ Paramedic Refresher

☐ EMS Instructor ☐ Immunization ☐ CEU (______ hrs) ☐ Community Paramedicine

Applicant Information (Please print)

Name:____
(Last) (First) (Middle)

Mailing Address____
(Street / P.O. Box) (City) (County) (State) (Zip)

DOB:______________________________ SS#:______________________________

Phone # :____________________/____________________ ☐ Male ☐ Female
(Home) (Work)

Employment Address:____
(Street) (City) (State) (Zip)

I / We certify that the above person has successfully completed the above noted EMS course.

Signed:____ Date:______________________________
Course physician of record with license number (Sign in **BLUE** ink)

Signed:____ Date:______________________________
EMS course coordinator (Sign in **BLUE** ink)

Course Completion Date:____________________ Final Written Evaluation: Pass / Fail (Circle One) Final Practical Evaluation: Pass / Fail (Circle One)

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
EMERGENCY MEDICAL SYSTEMS
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