

Ventura County Emergency Medical Services Agency Paramedic Training Program

Application Checklist

Sections 1-10 to be completed by training program

For additional information on requirements and approval process, please refer to VCEMS Policy 1135 – Paramedic Training Program Approval

1. General Information		
Training Program Name:		
Program Address	Program City	Program Zip
Program Phone Number	Program Fax Number	Program Email Address
2. Type of Institution		
<input type="checkbox"/> Accredited University or College <input type="checkbox"/> Junior College or Community College <input type="checkbox"/> School District <input type="checkbox"/> Private Post-Secondary School <i>(Submit Post-Secondary School Approval Document)</i> <input type="checkbox"/> Medical training unit of the United States Armed Forces or Coast Guard <input type="checkbox"/> Licensed general acute care hospital, with proof that facility meets the following criteria: <ul style="list-style-type: none"> <input type="checkbox"/> Hold a special permit to operate a basic or comprehensive emergency medical service pursuant to the provisions of the California Code of Regulations, Title 22, Division 5; <input type="checkbox"/> Provide continuing education (CE) to other health care professionals; and <input type="checkbox"/> Current accreditation by a Centers for Medicare and Medicaid Services (CMS) accreditation organization with deeming authority, such as the Joint Commission or the Healthcare Facilities Accreditation Program of the American Osteopathic Association <input type="checkbox"/> Agency of Government	Name of Institution or Agency	
3. Program Accreditation		
<input type="checkbox"/> Copy of a CoAEMSP LoR issued to the training institution applying for approval or documentation of current CAAHEP accreditation. <input type="checkbox"/> Sample of letter to training program applicants containing the following: <ul style="list-style-type: none"> <input type="checkbox"/> The date the paramedic training program must submit their CAAHEP Request for Accreditation Services (RAS) form and ISSR or the date their application for accreditation renewal was sent to CoAEMSP. <input type="checkbox"/> The date the paramedic training program must be initially accredited or the date its accreditation must be renewed by CAAHEP. <input type="checkbox"/> Copies of all documents submitted to, and received from CoAEMSP and/or CAAHEP including but not limited to the RAS form, ISSR, and any/all documents required for maintaining accreditation.		
4. Teaching Staff		
a. Program Medical Director <input type="checkbox"/> Copy of current license and certifications received <input type="checkbox"/> Evidence of experience in emergency medicine <input type="checkbox"/> Evidence of experience in education and/or methods of instruction	Name of Program Medical Director	
b. Program Director <input type="checkbox"/> Copy of current license and certifications received <input type="checkbox"/> Evidence of baccalaureate degree <input type="checkbox"/> Evidence of education and experience in methods, materials, and evaluation of instruction <input type="checkbox"/> Evidence of one (1) year experience in an administrative or management level position	Name of Program Director	

<input type="checkbox"/> Evidence of three (3) years academic or clinical experience in prehospital care education	
c. Principal Instructor(s) <input type="checkbox"/> Copy of current license(s) and certifications received <input type="checkbox"/> Evidence that individual(s) is knowledgeable in the course content of the January 2009 United States Department of Transportation (U.S. DOT) National Emergency Medical Services Education Standards DOT HS 811 077 E <input type="checkbox"/> Evidence of six (6) years of experience in an allied health field and an associate degree or two (2) years of experience in an allied health field and a baccalaureate degree. <input type="checkbox"/> Evidence of education and experience with at least forty (40) hours of documented teaching methodology instruction in areas related to methods, materials, and evaluation of instruction.	Name(s) and Title(s) of Principal Instructor(s) (MD, RN, PA, Paramedic)
d. Clinical Coordinator(s) (if applicable) <input type="checkbox"/> Copy of current license and certifications received <input type="checkbox"/> Documentation of at least two (2) years of academic and/or clinical experience in emergency medicine or prehospital care	Name(s) and Title(s) of Clinical Coordinator(s) (MD, RN, PA, Paramedic)
e. Teaching Assistant(s) <input type="checkbox"/> Copy of current license and certifications received <input type="checkbox"/> Evidence of qualification by training and experience to assist with teaching <input type="checkbox"/> Approval by program director in coordination with the program medical director	Names(s) and Title(s) of Teaching Assistant(s)
5. Hospital Clinical Education and Training	
<input type="checkbox"/> Provisions for supervised hospital clinical training including student evaluation criteria and standardized forms for evaluating paramedic students; and monitoring of preceptors by the training program. <input type="checkbox"/> Written agreements between the paramedic training program and a hospital(s) and other clinical setting(s), if applicable, for student placement for clinical education and training.	
6. Field Internship	
<input type="checkbox"/> Provisions for supervised field internship including student evaluation criteria and standardized forms for evaluating paramedic students; and monitoring of preceptors by the training program. <input type="checkbox"/> Written contracts or agreements between the paramedic training program and ALS provider agencies for student placement for field internship training.	
7. Required Course Hours and Content	
<input type="checkbox"/> Statement verifying that the course content meets the requirements contained in the U.S. DOT National Education Standards DOT HS 811 077 E January 2009. <input type="checkbox"/> Statement verifying program meets or exceeds required course hours outlined in Section V.E of this policy. <input type="checkbox"/> Outline of course objectives. <input type="checkbox"/> Performance objectives for each skill. <input type="checkbox"/> Samples of written and skills examinations administered by the training program. <input type="checkbox"/> Samples of a final written examination(s) administered by the training program.	
8. Training Program Facilities	
<input type="checkbox"/> The location at which the courses are to be offered and their proposed dates. <input type="checkbox"/> Evidence of adequate training program facilities, equipment, examination securities, and student record keeping.	
9. Administrative Requirements	
<input type="checkbox"/> Statement verifying program will comply with any/all reporting requirements outlined in Section V.L of this policy <input type="checkbox"/> Provide copy of course completion record <input type="checkbox"/> Provide copy of fee schedule <input type="checkbox"/> Provide copy of liability insurance for students	
10. Program Representative Completing Application	
Name of Program Representative Completing Application	
Signature	Date
Phone Number	Email Address

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1. Submission Checklist	
Required Item	Date Received
<input type="checkbox"/> Written request for program approval	
<input type="checkbox"/> Training program application checklist	
<input type="checkbox"/> Payment of established fee	
<input type="checkbox"/> Statement verifying that the course content meets the requirements contained in the U.S. DOT National Education Standards DOT HS 811 077 E January 2009.	
<input type="checkbox"/> Statement verifying program meets or exceeds required course hours outlined in Section V.E of this policy.	
<input type="checkbox"/> An outline of course objectives.	
<input type="checkbox"/> Performance objectives for each skill.	
<input type="checkbox"/> Names, CV/Resume, and copies of license(s)/cert(s) for each of the following: <input type="checkbox"/> Training program director <input type="checkbox"/> Program medical director <input type="checkbox"/> Principal instructor(s) <input type="checkbox"/> Clinical Coordinator(s) <input type="checkbox"/> Teaching Assistant(s)	
<input type="checkbox"/> Provisions for supervised hospital clinical training including student evaluation criteria and standardized forms for evaluating paramedic students; and monitoring of preceptors by the training program.	
<input type="checkbox"/> Provisions for supervised field internship including student evaluation criteria and standardized forms for evaluating paramedic students; and monitoring of preceptors by the training program.	
<input type="checkbox"/> The location at which the courses are to be offered and their proposed dates.	
<input type="checkbox"/> Written agreements between the paramedic training program and a hospital(s) and other clinical setting(s), if applicable, for student placement for clinical education and training.	
<input type="checkbox"/> Written contracts or agreements between the paramedic training program and ALS provider agencies for student placement for field internship training.	
<input type="checkbox"/> A copy of a CoAEMSP LoR issued to the training institution applying for approval or documentation of current CAAHEP accreditation.	
<input type="checkbox"/> Samples of written and skills examinations administered by the training program.	
<input type="checkbox"/> Samples of a final written examination(s) administered by the training program.	
<input type="checkbox"/> Evidence of adequate training program facilities, equipment, examination securities, and student record keeping.	
<input type="checkbox"/> Statement verifying program will comply with any/all reporting requirements outlined in Section V.L	
<input type="checkbox"/> Copy of Course Completion Record	
<input type="checkbox"/> Copy of Liability Insurance for Students	
<input type="checkbox"/> Copy of Fee Schedule	
2. Application Status	
Initial Application Received	Date
Additional Information Requested	Date
All Requirements Submitted	Date
Approval Letter Issued	Date
Approval Expiration	Date
3. EMS Agency Representative Information	
Name of EMS Agency Representative Reviewing Application	
Signature	Date
Phone Number	Email Address

