AURORA SOUTH WI EMS
W3985 County Road NN
Elkhorn, WI 53121

OFFICE OF MEDICAL DIRECTION
aah-ems@aah.org
262-743-3440

VERFICIATION OF COMPETENCY

EMERGENCY MEDICAL RESPONDER (EMR)

NEW SERVICE AFFILIATION ☐ LICENSE RENEWAL ☐ LICENSE UPGRADE ☐ TRANSFER ☐

EMS PROVIDER DEMOGRAPHICS

NAME:____ DATE: _________________________________

SERVICE: ____

WI LICENSE NUMBER:___________________________________

VERIFICATION PERIOD:

INITIAL ☐ ANNUAL ☐ SEMIANNUAL ☐

DOCUMENTATION OF VERIFICATION

Approved Demonstration Methods:

1. Demonstration of skills in simulation with the Office of Medical Direction; or
2. Documented successful performance of the skill during patient care; or
3. Completion of Medical Director approved training on the skill

	Date Completed:	Demonstration Method:	Evaluator Name & Title:
AIRWAY			
BVM Ventilation		1 ☐ 2 ☐ 3 ☐	
Supraglottic Airway		1 ☐ 2 ☐ 3 ☐	
CARDIAC			
Defibrillation (AED)		1 ☐ 2 ☐ 3 ☐	
ASSESSMENT			
Medical Patient		1 ☐ 2 ☐ 3 ☐	
Trauma Patient		1 ☐ 2 ☐ 3 ☐	

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	Date Completed:	Demonstration Method:	Evaluator Name & Title:
TRAUMA			
Bleeding Control		1 ☐ 2 ☐ 3 ☐	
MEDICATION			
Epinephrine (1:1000) Autoinjector		1 ☐ 2 ☐ 3 ☐	
Intranasal Medication Administration		1 ☐ 2 ☐ 3 ☐	

SIGNATURES

PROVIDER SIGNATURE:

Print Name: ____________ Date: ____________ Signature: ____________

SERVICE DIRECTOR VALIDATION:

Print Name: ____________ Date: ____________ Signature: ____________

MEDICAL DIRECTOR APPROVAL:

Print Name: ____________ Date: ____________ Signature: ____________