National Registry of Emergency Medical Technicians®

THE NATION'S EMS CERTIFICATION"



EMT Psychomotor Examination Verification

Candidate Name		Application Confirmation Number		
Address		City	State	Zip
Email		Phone Number		
To Be Comple	ted by the Instructor, Training C	Officer or EMS	Service Director:	
I verify that	(candidate nan	ne) has completed	d a state-approved psychomol	or examination equal
to or exceeding t	he criteria established by the NREMT	and performed sa	tisfactorily so as to be deeme	d competent in the
following skills:				
	Patient Assessment/Management –	Medical		
	Patient Assessment/Management – Trauma			
•	Bag Valve – Mask (Apneic Adult Patient)			
•	Oxygen Administration by Non-rebreather Mask			
	Cardiac Arrest Management/AED			
	Spinal Immobilization (Supine Patient)			
•	Random Skill Verification	•	_	
Psychomotor Ex	am Location		Psychomotor Exam Date	
			Title	
			Date	
I hereby affirm that	all statements on the EMT Psychomo	otor Evamination \	Perification are true and correc	t It is understood that
-	ay be sufficient cause for revocation b			
of the activities liste	•	by the NNLWIT. It	is also understood that MINEW	ir may conduct an addit
or the activities list	ou at any time.			
Candidate Signatu	re		Date _	