| ***FOR OFFICE USE ONLY*** | |
|---|---|
| Check #: | Date: |
| ID#: | |
| Receipt #: | |

# Rhode Island Department of Health
# Division of Health Services Regulation
# Emergency Medical Services

Room 103
3 Capitol Hill
Providence, RI 02908-5097

## *Application For Authorization to Practice the Extended Role Skill - Orotracheal/Endotracheal Intubation*

*Applicant - Print Name (First/MI/Last)*

*RI - EMT License Number*

**Health Department Use ONLY**

- ☐ Manikin Testing Sheet received
- ☐ Current EMT License Verified

☐ Approved ☐ Denied Date: _____

Signature: _____

**Phone: (401) 222-2401** **Fax: (401) 222-3352** **TTY/TDD: (800) 745-5555**

Revised 02/22/2011jcp

**Name:**

**Address:**

**City:** **State:** **ZipCode:**

**Social Security Number:** **Home Telephone:**

---

**Name of Organization Sponsoring Course:**

**Location of Training Program:**

**Starting Date:** **Ending Date:**

**RI Department of Health Course Approval Number:**

**Name of Course Medical Director:**

**Name of Course Instructor Coordinator:**

**Signature of Student:** **Date:**

---

**Mail To:**

**Rhode Island Department of Health**
**Division of Emergency Medical Services**
**Room 105, 3 Capitol Hill**
**Providence, RI 02908-5097**

---

***Rules and Regulations/Laws***

The "Rules and Regulations Relating to Emergency Medical Services" can be obtained at the following web site:

**http://www.health.ri.gov/hsr/professions/amb.php**

Title 23, Chapter4.1, entitled:

Emergency Medical Transportation Services can be downloaded at the following web site:

**http://www.rilin.state.ri.us/statutes/title23/23-4.1/INDEX.HTM**

# EMT-EXTENDED ROLE
# OROTRACHEAL/ENDOTRACHEAL INTUBATION TRAINING PROGRAM

Module II Manikin Testing Sheet

**Name of Student:** **EMT#**

**PART I:**
**Student must demonstrate proficiency in ventilating adult and pediatric manikins with mask technique.**

**CIRCLE ONE:** **PASS** **FAIL**

**Full signature of Evaluation** **Date**

**PART II:**
**Student must safely and effectively perform the skill of orotracheal/endotracheal intubation.**

**Medical:** **Head Tilt/Chin Lift**
**Trauma:** **Sniff/Neutral Position**

| Date | Medical | Trauma | Adult | Pediatric | Full Signature of Evaluator |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**I hereby certify that the above-named student has safely and effectively performed the skill of orotracheal/ endotracheal intubation under my supervision, and I recommend certification in the extended skill of orotracheal/endotracheal intubation.**

**Instructor-Coordinator** **Physician Medical Director or Designee**