EMT-EXTENDED ROLE SKILL
IV ANTICOAGULANT THERAPY
REQUEST FOR AUTHORIZATION TO PRACTICE

NAME _____
LAST FIRST MI

ADDRESS _____

CITY/STATE _____ ZIP CODE _____

SOCIAL SECURITY # _____ HOME TELEPHONE _____

DATE OF BIRTH _____ EMT # _____

LOCATION OF TRAINING PROGRAM _____

STARTING DATE _____ ENDING DATE _____

RI DOH COURSE APPROVAL # _____

NAME OF COURSE MEDICAL DIRECTOR _____

NAME OF COURSE INSTRUCTOR-COORDINATOR _____

SIGNATURE OF STUDENT _____ DATE _____

* *

HEALTH DEPARTMENT USE ONLY

- ☐ Documentation of course completion received
- ☐ Current RI EMT license verified
- ☐ Verification of approved IV Anticoag. Ther. Training Program

Authorization to practice skill approved on _____
Signature _____

Authorization to practice skill denied on _____
Signature _____