EMT-EXTENDED ROLE SKILL
IV NITROGLYCERIN
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 Nitroglycerin Training Program

Authorization to practice skill approved on _____
Signature_____

Authorization to practice skill denied on_____
Signature _____