SAN JOAQUIN COUNTY EMERGENCY MEDICAL SERVICES AGENCY

TITLE: MICN CONTINUING EDUCATION FORM					EMS Policy No. 2610B	
Name of MICN:				Authorization #:		
Emp	loyer: _			Base Hospital:		
	Date	Attended	Field Care Aud	dit Instructor	# Hours	
1						
2						
3						
4						
5						
6						
	<u> </u>					
Ambulance Observation Time (Optional)						
Date		Ambulance Provider Name			Paramedic Name	
Tota	l Hours	:				
Verified by:Date:						
verified by				Date		
I cer	tify tha	t the above int	ormation is true and co	orrect:		
MICN's Signature				 Date		
WIICIN	3 Olgila	ture		_	die	
Effective: June 1, 2021					Page 1 of 1	
Supe	rsedes:	June 15, 200	р			
	_		6 11	. .	6 12	
Appro	oved:	Signature on	<u>tile</u>	<u>Signatur</u>	<u>e on tile</u>	

roved: Signature on file Signature on file EMS Administrator