TITLE: **MICN CONTINUING EDUCATION FORM** EMS Policy No. **2610B**

Name of MICN: ______________________________ Authorization #: ___________

Employer: _____________________________ Base Hospital: ___________________

	Date Attended	Field Care Audit Instructor	# Hours
1			
2			
3			
4			
5			
6			

Ambulance Observation Time (Optional)		
Date	Ambulance Provider Name	Paramedic Name

Total Hours:__________

Verified by:_______________________________________Date:____________________

I certify that the above information is true and correct:

______________________________ ______________________
MICN's Signature Date

Approved: Signature on file Signature on file
Medical Director EMS Administrator