MICN ORIENTATION VERIFICATION

Sponsoring Base Hospital: _____

Applicant Name: _____
(Please Print)

Prehospital Liaison Nurse Name: _____
(Please Print)

This is to certify that the above named applicant has successfully completed all the items listed below:

1. Successfully complete a supervised pre-authorization evaluation to consist of no less than ten (10) actual or simulated ALS base contacts.

2. Demonstrate knowledge of skills and medications which are part of the San Joaquin County Paramedic expanded scope of practice.

_____ _____
PLN Signature Date

Approved: Signature on file
Medical Director

Signature on file
EMS Administrator