SAN JOAQUIN COUNTY
EMERGENCY MEDICAL SERVICES AGENCY

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

Name of MICN: _____ Authorization #: _____

Employer: _____ Base Hospital: _____

Date	Course Title	CE Provider Name & Number	# Hours

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

Effective: **6/15/06** Page 1 of 1
Revised:
Supersedes:

Approved: Signature on file
Medical Director

Signature on file
EMS Administrator