



FOR OFFICIAL USE ONLY
 CLASSIFICATION _____
 CERT. NUMBER _____
 DATE ISSUED _____

State of West Virginia

Jim Justice, Governor

WV Office of Miners' Health, Safety & Training

Greg Norman, Director

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www.wvminesafety.org

EMERGENCY MEDICAL TECHNICIAN-M AND INSTRUCTOR APPLICATION

<u>Type of Application (Check all that apply)</u>		
<input type="checkbox"/> EMT-Miner 60 Hour <input type="checkbox"/> Grandfathered	<input type="checkbox"/> EMT-Miner Recertification <input type="checkbox"/> 8 Hour <input type="checkbox"/> 32 Hour	<input type="checkbox"/> EMT-M Instructor <input type="checkbox"/> EMT-M Reciprocity
Last Name:	First:	MI:
DOB:	SSN:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Phone (H):	Phone (C):	Email:
Mailing Address:	City/County:	State/Zip:

- **Initial** applicants for EMT-M certification must show verification of current CPR Certification.
- When **recertifying** as an EMT-M the applicant must submit verification of current CPR certification.
- **EMT-M Instructors** must submit documentation of their certification or qualification as a first aid instructor and verification that they are a current **CPR Instructor**.
- When requesting **reciprocity** as an EMT-M, you must attach all documentation verifying your training, certification (if applicable) and experience in the medical field.

Failure to fully and truthfully complete this application will result in your application being rejected or certification delayed or refused.

I swear or affirm that I meet all requirements for certification as an EMT-Miner or EMT-M Instructor and do hereby swear or affirm the information given on this application is true and correct.

Applicants Signature:

Date:

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Written Exam Score _____

Practical Exam:	Patient Assess/Mgmt Medical <input type="checkbox"/>	Patient Assess/Mgmt Trauma <input type="checkbox"/>	Baseline – Vitals <input type="checkbox"/>	Cardiac / AED <input type="checkbox"/>	Airway Mgmt <input type="checkbox"/>
Bleeding Ctrl/Shock Mgmt <input type="checkbox"/>	Immobilization – Extremities <input type="checkbox"/>	Immobilization – Seated (KED) <input type="checkbox"/>	Immobilization – Traction Splint <input type="checkbox"/>	Immobilization – Seated Supine <input type="checkbox"/>	

WV OFFICE OF MINERS' HEALTH, SAFETY AND TRAINING

STUDENT ROSTER

Instructor: _____

Instructor Phone: _____

Directions: _____

Please mark appropriate box: **Initial Roster** (Must include instructor's contact information and directions to the training facility.)

Final Roster (Must include individuals who have successfully completed the course.)

Number Enrolled: _____

Initial EMT-M Course: _____

Retraining Module: 1 2 3 4

1	Student's Last Name	Student's First Name	Mailing Address	Last four (4) of Social
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

I verify that persons on this final roster have successfully completed the cognitive and skills evaluation in the above listed course.

Signature of Instructor: _____

Course Date(s): _____