Revised 1-2018

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CLASSIFICATION_____
CERT. NUMBER_____
DATE ISSUED _____

State of West Virginia

WV Office of Miners' Health, Safety & Training
Greg Norman, Director
#7 Players Club Drive, Suite 2 ▪ Charleston, West Virginia ▪ 25311-1626
Telephone 304-558-1425 ▪ Fax 304-558-1282
www.wvminesafety.org

EMERGENCY MEDICAL TECHNICIAN-M AND INSTRUCTOR APPLICATION

Type of Application (Check all that apply)		
□ **EMT-Miner 60 Hour** □ **Grandfathered**	□ **EMT-Miner Recertification** □ **8 Hour** □ **32 Hour**	□ **EMT-M Instructor** □ **EMT-M Reciprocity**
Last Name:	**First:**	**MI:**
DOB:	**SSN:**	□ **Male** □ **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 ☐	Patient Assess/Mgmt Trauma ☐	Baseline – Vitals ☐	Cardiac / AED ☐	Airway Mgmt ☐	
Bleeding Ctrl/Shock Mgmt ☐	Immobilization – Extremities ☐	Immobilization – Seated (KED) ☐	Immobilization – Traction Splint ☐	Immobilization – Seated Supine ☐	

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** ☐

	Student's Last Name	Student's First Name	Mailing Address	Last four (4) of Social
1				
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): _____**

Region One 14 Commerce Dr., Suite 1, Westover, West Virginia 26501 Telephone 304-285-3268 Fax 304-285-3275
Region Two 891 Stewart St. Welch, West Virginia 24801-231 Telephone 304-436-8421 Fax 304-436-2100
Region Three 137 Peach Court, Suite 2 Danville, West Virginia 25053 Telephone 304-369-7823 Fax 304-369-7826
Region Four 550 Industrial Dr. Oak Hill West Virginia 25901-9714 Telephone 304-469-8100 Fax 304-469-4059