

EMERGENCY MEDICAL TECHNICIAN – EMT AMBULANCE SERVICE SUPPORT

Initial Course Only

Service Name		
Mailing Address		
City	State	Zip Code
Director/Manager		

A signed copy of this form or equivalent must be submitted to the OEMS for each service used.

As director of above mentioned ambulance service I agree to provide a setting for conducting the clinical for the EMT training program to be held at named city. I understand the ambulance experience will involve the EMT students observing and participating under supervision in all aspects of patient care as carried out by this service within the scope of practice of an EMT. The ambulance clinical experience will be under the supervision of the medical director of the service on record. I understand this agreement may be terminated under written notice to the training program director and the Office of EMS.

Signature of Ambulance Service Director/Manager

Date