CFR and EMT

Mandatory Annual Skills Evaluation Form

Name: ______________________________ Date: ____________________

Certification #: ______________________________ CPR Expiration: ____________________

Certification Expiration: ______________________________

Primary EMS Agency: ______________________________

Email Address: ______________________________

Circle Method Used to Demonstrate Skill (See options below)

Certified First Responder Skills Evaluation

Skill	Date	Evaluator			
AED	Date: __________	Evaluator: __________	**1**	**2**	**3**
BLS Naloxone *	Date: __________	Evaluator: __________	**1**	**2**	**3**
Epi-Pen *	Date: __________	Evaluator: __________	**1**	**2**	**3**

EMT Skills Evaluation

Skill	Date	Evaluator			
AED	Date: __________	Evaluator: __________	**1**	**2**	**3**
BLS Naloxone *	Date: __________	Evaluator: __________	**1**	**2**	**3**
Nebulized Albuterol *	Date: __________	Evaluator: __________	**1**	**2**	**3**
Blood Glucose Monitoring*	Date: __________	Evaluator: __________	**1**	**2**	**3**
BLS EKG Monitoring*	Date: __________	Evaluator: __________	**1**	**2**	**3**
Epi-Pen *	Date: __________	Evaluator: __________	**1**	**2**	**3**
IM Syringe Epi*	Date: __________	Evaluator: __________	**1**	**2**	**3**
CPAP*	Date: __________	Evaluator: __________	**1**	**2**	**3**

*** Demonstrated only if agency is credentialed to use the skill**

Annual Skills Verification (Evaluator): ______________________________ ______________________________

Print Signature

Provider Signature: ______________________________

Medical Director Name: ______________________________

Skill competency shall be demonstrated to the medical director (or his designee), as follows:

1. Demonstrate the skill **2.** Verified the skill from QA/QI **3.** Attending an approved Med Dir training

****A copy of this summary must be maintained in each providers agency file.****