Sacramento County
Emergency Medical Services Agency
9616 Micron Avenue, Suite 940, Sacramento, CA 95827
(916) 875-9753
SCEMSAInfo@saccounty.gov

Paramedic Infrequent or Critical Skills Verification

Skills verification shall be verified by direct observation of an actual or simulated patient contact, within the individual's licensure cycle.

Provider Agency: _____ Calendar Year: _____

Paramedics Name: _____ License Number: _____

Skills Verification *Minimum Standards*

1. Needle Chest Decompression
   - 1.1. Date of Verification: _____
   - 1.2. Evaluator(s) Name and License Number: _____#_____
2. Pediatric Airway Management
   - 2.1. Date of Verification: _____
   - 2.2. Evaluator(s) Name and License Number: _____#_____
3. Adult Airway Management
   - 3.1. Date of Verification: _____
   - 3.2. Evaluator(s) Name and License Number: _____#_____
4. Hemorrhage Control
   - 4.1. Date of Verification: _____
   - 4.2. Evaluator(s) Name and License Number: _____#_____
5. Transcutaneous Cardiac Pacing and Cardioversion (Adult and Pediatrics)
   - 5.1. Date of Verification: _____
   - 5.2. Evaluator(s) Name and License Number: _____#_____
6. External Jugular (EJ) IV Cannulation
   - 6.1. Date of Verification: _____
   - 6.2. Evaluator(s) Name and License Number: _____#_____
7. Medication Administration: Nerve Agent Exposure, Ketamine, Epinephrine Dilution.
   - 7.1. Date of Verification: _____
   - Evaluator(s) Name and License Number: _____ _____
8. Emergency Childbirth
   - 8.1. Date of Verification: _____
   - 8.2. Evaluator(s) Name and License Number: _____#_____

9. Interosseous Placement and Infusion (in order of preference)

Vascular Access:

Adult:

- ☐ Proximal Humerus
- ☐ Proximal Tibia
- ☐ Distal Tibia

9.1. Date of Verification: _____

9.2. Evaluator(s) Name and License Number: _____#_____

Pediatric:

- ☐ Proximal Tibia
- ☐ Distal Tibia
- ☐ Distal Femur

9.3. Date of Verification: _____

9.4. Evaluator(s) Name and License Number: _____#_____

I certify all information on this form, to the best of my knowledge, is true and correct.

Signature of EMS Coordinator/EMS Training Coordinator: _____

Print to Sign

Name: _____

Date: _____

EMS Approved Training Agency: _____

Clear Form