

COASTAL VALLEYS EMS AGENCY



PARAMEDIC PRECEPTOR/EVALUATOR APPLICATION

NAME _____
Last First Middle

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE # (____) _____ WORK PHONE # (____) _____

EMAIL ADDRESS _____ CELL # (____) _____

CA PARAMEDIC LICENSE # _____ INITIAL ISSUE DATE __/__/__ CVEMSA INITIAL ACCREDITATION DATE __/__/__

CURRENT ADVANCED LIFE SUPPORT EMPLOYER (S) _____

PRECEPTOR/EVALUATOR WORKSHOP PROGRAM _____ DATE: __/__/__ INSTRUCTOR _____

COUNTY ACCREDITATIONS CURRENT/PRIOR _____

Have you ever been the subject of a formal prehospital care certification/licensure disciplinary action or proceeding?

yes no if yes, explain _____

APPLICANT SIGNATURE _____ DATE __/__/__

AGENCY ENDORSEMENT:

This portion must be completed by an authorized officer of the provider agency which the applicant will Precept/Evaluate.

I recommend the above named applicant be approved as a Preceptor/Evaluator within the CVEMSA Region, and applicable to our agency/organization.

CVEMS AUTHORIZED ALS PROVIDER AGENCY _____ DATE __/__/__

AUTHORIZING OFFICER _____ TITLE _____ SIGNATURE _____
Please print name

Forward completed application with a copy of applicant's Preceptor/Evaluator Workshop CE Certificate to:

Coastal Valleys EMS Agency
195 Concourse Blvd. Suite B, Santa Rosa, CA 95403
Office (707) 565-6501 Fax (707) 565-6510
Documents may be submitted as .pdf scan copies via email to: james.salvante@sonoma-county.org

FOR OFFICE USE ONLY

Paramedic License # _____ Issued __/__/__ Expires __/__/__ Application Received __/__/__ Approved __/__/__ Denied __/__/__

Reviewed By: Name, Title _____ Signature _____