



## EMT Psychomotor Examination Verification

Candidate Name \_\_\_\_\_ Application Confirmation Number \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email \_\_\_\_\_ Phone Number \_\_\_\_\_

### To Be Completed by the Instructor, Training Officer or EMS Service Director:

I verify that \_\_\_\_\_ (candidate name) has completed a state-approved psychomotor examination equal to or exceeding the criteria established by the NREMT and performed satisfactorily so as to be deemed competent in the following skills:

- Patient Assessment/Management – Medical
- Patient Assessment/Management – Trauma
- BVM Ventilation (Apneic Adult Patient)
- Oxygen Administration by Non-rebreather Mask
- Cardiac Arrest Management/AED
- Spinal Immobilization (Supine Patient)
- Random Skill Verification \_\_\_\_\_

Psychomotor Exam Location \_\_\_\_\_ Psychomotor Exam Date \_\_\_\_\_  
Name (print) \_\_\_\_\_ Title \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby affirm that all statements on the EMT Psychomotor Examination Verification are true and correct. It is understood that false statements may be sufficient cause for revocation by the NREMT. It is also understood that NREMT may conduct an audit of the activities listed at any time.

Candidate Signature \_\_\_\_\_ Date \_\_\_\_\_