



**National Registry of Emergency Medical Technicians
Emergency Medical Technician Psychomotor Examination**

**Verification Form
Candidate Information**

Name _____ Application Confirmation Number _____

Address _____

City _____ State _____ Zip _____ -

Phone _____ Email _____

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 – Trauma
- Patient Assessment/Management – Medical
- BVM Ventilation (Apneic Adult Patient)
- Oxygen Administration by Non-rebreather Mask
- Cardiac Arrest Management/AED
- Spinal Immobilization (Supine Patient)
- Random Skill Verification
 - Spinal Immobilization (Seated Patient)
 - Bleeding Control/Shock Management
 - Long Bone Immobilization
 - Joint Immobilization

_____ Psychomotor Exam Location

_____ Exam Date

_____ Name of person verifying psychomotor examination

_____ 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 and other appropriate actions by the NREMT. It is also understood that NREMT may conduct an audit of the skills listed at any time.

Candidate Signature _____

Date _____