



BLS Psychomotor Competency Application & Verification

Candidate Information

Name _____ Application Type: EMR EMT

Address _____

City _____ State _____ Zip Code _____

Phone _____ E-mail Address _____

I hereby affirm that all statements on the BLS Psychomotor Competency Verification Form are true and correct. It is understood that false statements may be sufficient cause for revocation and other appropriate actions by the Virginia Office of EMS. It is also understood that the Virginia Office of EMS may conduct an audit of the skills listed at any time.

Candidate Signature _____ Date _____

To Be Completed by Virginia certified Education Coordinator:

I verify that _____ (candidate name) has completed the Virginia approved psychomotor competency verification as described in **Psychomotor Competency Verification Guidance for Legal Recognition, Reentry & Challenge** and that a copy of this form and the TR-20 – Virginia Competency-based Psychomotor Scenario Evaluation forms have been submitted to the Office of EMS for scoring.

Psychomotor Exam Location	Verification Date
Education Coordinator Printed Name	Title
Education Coordinator Signature	Date

Virginia Office of Emergency Medical Services

1041 Technology Park Drive

Glen Allen, VA 23059

804-888-9100

<http://www.vdh.virginia.gov/emergency-medical-services/>

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