TEXAS DEPARTMENT OF STATE HEALTH SERVICES
EMS Certification & Licensing Group
Cash Receipts Branch, MC 2003
P.O. Box 149347
Austin, Texas 78714-9347
(512) 834-6700 FAX (512) 834-6714

DAVID L. LAKEY, M.D.
COMMISSIONER

SKILLS PROFICIENCY FORM

All information given on this form is considered public record, with exception of social security number*. Candidate should submit this form with the recertification application. Successful completion of skills proficiency verification must be within 6 months of recertification application date.

* Disclosure of your social security number is mandatory under Family Code, Chapter 232

PLEASE CHECK THE LEVEL OF SKILL PERFORMED.

☐ **Basic Skills Proficiency Verification for ECA shall consist of:**

- Bandaging and Splinting
- Mechanical Aids to Breath
- Spinal Immobilization
- Traction Splinting
- Physical Assessment of Patient
- CPR

☐ **IN ADDITION TO THE ABOVE, EMT (1994 Curriculum) Skills Proficiency Verification shall consist of:**

- Epinephrine Auto-Injector
- Bronchodilator Administration
- Cardiac Arrest Management/AED
- Pneumatic Anti-shock Garment

☐ **IN ADDITION TO THE ABOVE, Advanced EMT Skills Proficiency Verification shall consist**

- Peripheral Venipuncture
- Adult Endotracheal Intubation
- Esophageal Intubation
- Infant Endotracheal Intubation

☐ **IN ADDITION TO THE ABOVE, EMT-P Skills Proficiency Verification shall consist of:**

- Drug Administration
- Defibrillation/Cardioversion
- Megacode

Candidate's Last Name _____ First _____ Social Security or EMS ID # _____

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* * * TO BE FILLED OUT BY A TEXAS CERTIFIED EMS COORDINATOR * * *

I verify that the proficiency of the candidate has been examined and verified as competent in the application of all required skills.

I understand that by signing this document I am attesting that all of the information on this document is true and correct. I also understand that the DSHS will take action against my EMS certification(s) if the information submitted is found to have been falsified.

EMS Coordinator Signature: _____ Date _____

Print Coordinator Last Name, First Name, M.I. _____

Coordinator EMS ID Number _____

Program Telephone Number _____

Program Fax Number _____