



TEXAS Health and Human Services

Texas Department of State Health Services

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

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 #

*** 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