



South Plains EMS Skills Proficiency Form



Date: _____

PRINTED Name: _____

Certification Level (Circle one): **EMT** **EMT-I** **EMT-P** **LP**

Affiliated Services: _____

First Six Month Period: January 1 – June 30, _____ Second Six Month Period: July 1 – December 31, _____

ECA	AED	Epi IM								
EMT	AED	Epi IM	King Airway							
EMT-I	AED	Epi IM	King Airway	IV	Pleural Decompression	EZ IO Adult	EZ IO Pedi	ETT		
EMT-P LP	Surgical Cric.	Needle Cric.	King Airway	IV	Pleural Decompression	EZ IO Adult	EZ IO Pedi	ETT	Defibrillation	

I certify that the above individual has demonstrated proficiency in the above marked skills.

Location: _____ **Peer Review/Instructor:** _____

Peer Reviewer/Instructor Signature: _____

