



# ANNUAL SKILLS AND POLICY REVIEW FORM-6091



<b>1a. Name as shown on Paramedic License:</b>		<b>1b. License Number</b>	
<b>1c. Signature of person demonstrating competency</b>		<b>1d. Employer</b>	
Skill	Verification of Competency		
<b>1. Orotracheal Intubation (Adult)</b>	<b>Verifier Affiliation:</b>	<b>Date:</b>	
Signature of person verifying competency	<b>Print Name:</b>	<b>Certification/License Number:</b>	
<b>2. Supraglottic Airway (Adult)</b>	<b>Verifier Affiliation:</b>	<b>Date:</b>	
Signature of person verifying competency	<b>Print Name:</b>	<b>Certification/License Number:</b>	
<b>3. Pleural Decompression</b>	<b>Verifier Affiliation:</b>	<b>Date:</b>	
Signature of person verifying competency	<b>Print Name:</b>	<b>Certification/License Number:</b>	
<b>4. Transcutaneous Cardiac Pacing</b>	<b>Verifier Affiliation:</b>	<b>Date:</b>	
Signature of person verifying competency	<b>Print Name:</b>	<b>Certification/License Number:</b>	
<b>5. Synchronized Cardioversion</b>	<b>Verifier Affiliation:</b>	<b>Date:</b>	
Signature of person verifying competency	<b>Print Name:</b>	<b>Certification/License Number:</b>	
<b>6. EZ IO (Adult/Pediatric)</b>	<b>Verifier Affiliation:</b>	<b>Date:</b>	
Signature of person verifying competency	<b>Print Name:</b>	<b>Certification/License Number:</b>	
<b>7. Annual Protocol/Policy Review</b>	<b>Verifier Affiliation:</b>	<b>Date:</b>	
Signature of person verifying competency:	<b>Print Name:</b>	<b>Certification/License Number:</b>	

A completed Annual Skills and Policy Review Form is required to accompany a paramedic reaccreditation application for every individual who is either maintaining paramedic accreditation without a lapse, or to renew paramedic accreditation with a lapse of less than six months.

**1a. Name of Paramedic License Holder**

Provide the complete name, last name first, of the paramedic accreditation demonstrating skills competency.

**1b. Paramedic License Number**

Provide the paramedic license number for the current or lapsed paramedic accreditation.

**1c. Signature**

Signature of the paramedic. By signing this section, the paramedic is verifying that the information contained on this form is accurate and that the paramedic has demonstrated competency in the skills listed in the skills sheet.

**1d. Employer**

Provide the name of the current paramedic employer(s).

**Verification of Competency**

1. Verifier Affiliation: Provide the name of the EMS service provider or base hospital that the qualified individual who is verifying competency is affiliated with.
2. Once competency has been demonstrated by direct observation of an actual or simulated patient contact, i.e. skills station, the individual verifying competency shall sign the Annual Skills and Policy Review Form for that skill.
3. Qualified individuals who verify skills competency shall be currently licensed as: a paramedic, registered nurse, physician assistant, or physician and shall be either a qualified instructor designated by an EMS approved training program (paramedic training program or continuing education training program) or be a qualified individual designated by an EMS service provider. EMS service providers include, but are not limited to, public safety agencies, private ambulance providers, and other EMS providers.
4. License Number: Provide the certification or license number for the individual verifying competency.
5. Date: Enter the date that the individual demonstrated competency in each skill.
6. Print name – Print the name of the individual verifying competency in the skill.

A completed Annual Skills and Policy Review Form shall be provided to the Monterey County EMS Agency for every paramedic reaccreditation cycle in compliance with Policy 2050. A copy of this form shall be retained by the paramedic license holder, and the EMS provider agency for a minimum of 4 years as outlined in Monterey County EMS System Policy 6090.