Level_____Type_____-
Start Date_____End Date_____
Course #_____Location_____

Idaho EMS Bureau

EMT - Basic Skills Evaluation Record

Student Name: _____ (for instructor use, copy as needed)

Module #	Practical Skill Sheet	Date	Evaluator	S	U
	Oxygen Administration				
	Mouth to Mask with Oxygen				
	Upper Airway Adjuncts / Suction				
	BVM Ventilatory Management				
	Bleeding Control / Shock				
	Spinal Immobilization Seated				
	Spinal Immobilization Supine				
	Traction Splinting				
	Long Bone Immobilization				
	Joint Immobilization				
	Cardiac Arrest Management / AED				
	Patient Assessment - Trauma				
	Patient Assessment - Medical				
	Epinephrine Auto Injector				

Comments:

I verify that the information on this document is true and correct.

Course Coordinator Signature _____ Date _____