

# CERTIFICATE OF COMPLETION PROTOCOL EVALUATION

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(NAME)

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(SERVICE)

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(LEVEL)

Date Completed: \_\_\_\_\_

Approved for 6 hours Continuing Education

State Approved Course Number \_\_\_\_\_

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(Print) TRAINER NAME

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TRAINEE SIGNATURE

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TRAINER SIGNATURE

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MEDICAL DIRECTOR SIGNATURE

Signatures from both the Trainer and Medical Director are required if you work for an EMS Agency that provides ALS services.