CERTIFICATE OF COMPLETION
PROTOCOL EVALUATION

(NAME)

(SERVICE)

(LEVEL)

Date Completed: _____

Approved for 6 hours Continuing Education
State Approved Course Number _____

(Print) TRAINER NAME

TRAINEE SIGNATURE

TRAINER SIGNATURE

MEDICAL DIRECTOR SIGNATURE

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