

REQUEST FOR INITIAL COURSE APPROVAL – EMT-I

Board of EMS 900 SW Jackson Street Room 1031 Topeka, KS 66612-1228 785-296-7296

***** TYPE OR PRINT CLEARLY *****

CAN APPROVAL DOCUMENTS BE SENT ELECTRONICALLY? ☐ YES ☐ NO
IF YES, BE SURE TO INCLUDE EMAIL BELOW.

LEVEL: ☐ Emergency Medical Technician - Intermediate

EDUCATOR NAME: FIRST: _____ LAST: _____

STREET: _____

CITY: _____ STATE: _____ ZIP: _____

EDUCATOR'S SSN: _____ EMAIL: _____

YOUR SOCIAL SECURITY NUMBER IS REQUIRED PURSUANT TO K.S.A. 74-148 AND K.S.A 74-139, AND MAY BE USED FOR CHILD SUPPORT ENFORCEMENT PURPOSES OR PROVIDED TO THE KANSAS DIRECTOR OF TAXATION, UPON REQUEST.

DATE OF FIRST CLASS: _____ DATE OF LAST CLASS: _____

SPONSORING ORGANIZATION: _____

PROGRAM COORDINATOR NAME: FIRST: _____ LAST: _____

PHONE: () _____ EMAIL: _____

MEDICAL ADVISOR: _____ PHONE: _____

COURSE LOCATION: _____ ROOM# _____ STREET: _____

CITY: _____ STATE: _____ COUNTY: _____ EMS REGION: _____

DAYS CLASSES TO BE HELD:

☐ SUN ☐ MON ☐ TUE ☐ WED ☐ THURS ☐ FRI ☐ SAT

CLASS TIME: BEGINNING: _____ ENDING: _____

NUMBER OF LECTURE HOURS: _____ NUMBER OF LAB HOURS: _____

NUMBER OF CLINICAL HOURS: _____ NUMBER OF FIELD HOURS: _____

TOTAL COURSE HOURS: _____

ANTICIPATED NUMBER OF STUDENTS: _____

IS THIS COURSE BEING GIVEN FOR COLLEGE CREDIT? ☐ YES ☐ NO

IF YES, PROVIDE NAME OF INSTITUTION GRANTING CREDIT:

IS THIS CLASS BEING SUBMITTED FOR EDUCATIONAL INCENTIVE GRANT FUNDING? ☐ YES ☐ NO

FOR OFFICE USE ONLY

Assurances and Certifications

We the undersigned assure and certify that the training program for which we seek approval from the Kansas Board of EMS will offer this course in compliance with the authority and requirements of the training program approval granted by the Kansas Board of EMS as described in Kansas statutes annotated and Kansas administrative regulations.

Furthermore, we assure and certify that the Kansas Board of EMS will be provided copies of any and all training program records upon request.

THE INFORMATION PROVIDED IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I ALSO AGREE THAT SUBMISSION OF THIS FORM TO THE KANSAS BOARD OF EMERGENCY MEDICAL SERVICES ELECTRONICALLY OR BY FACSIMILE WILL HAVE THE SAME FORCE AND EFFECT AS AN ORIGINAL FORM SIGNED BY ME UNDER PENALTY OF PERJURY.

PROGRAM COORDINATOR SIGNATURE

DATE

PRIMARY INSTRUCTOR SIGNATURE

DATE

MEDICAL ADVISOR SIGNATURE

DATE

THIS FORM SHALL BE RECEIVED IN THE BOARD'S OFFICE AT LEAST 30 DAYS PRIOR TO THE FIRST SCHEDULED CLASS SESSION.

FOR BEMS USE ONLY

THIS COURSE IS: ☐ APPROVED

CIN: _____ - _____

☐ DENIED

BEMS REPRESENTATIVE SIGNATURE

DATE