



# EMT-Extended Role Skill Request for Authorization to Practice OROTRACHEAL/ENDOTRACHEAL INTUBATION

[PLEASE PRINT]

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ Home Telephone \_\_\_\_\_

Date of Birth \_\_\_\_\_ EMT # \_\_\_\_\_ EMT Exp. Date \_\_\_\_\_

Name of Organization Sponsoring Course \_\_\_\_\_

Location of Training Program \_\_\_\_\_

Starting Date \_\_\_\_\_ Ending Date \_\_\_\_\_

RIDOH Course Approval # \_\_\_\_\_

Name of Course Medical Director \_\_\_\_\_

Name of Course Instructor-Coordinator \_\_\_\_\_

Signature of Student \_\_\_\_\_ Date \_\_\_\_\_

[HEALTH DEPARTMENT USE ONLY]

- Manikin Testing Sheet received
- Current RI EMT license verified
- Approved Oro/Endotracheal Intubation program

**OROTRACHEAL/ENDOTRACHEAL CERTIFICATION APPROVED**

**ON \_\_\_\_\_ AND WILL EXPIRE ON \_\_\_\_\_.**

**OROTRACHEAL/ENDOTRACHEAL CERTIFICATION DENIED ON \_\_\_\_\_.**

**SIGNATURE \_\_\_\_\_**

