



DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
Emergency Medical Services Office
 194 Hernan Cortez Avenue, Suite 213, Terlaje Professional Building,
 Hagatna, Guam 96910
 (671)735-7411 or (671) 735-7412



COURSE APPROVAL REQUEST

FOR OFFICE USE

bbfs042721

Date Received & By: _____

Date Received & By: _____

 / / Approved / / Disapproved

 Breanna Sablan
 Acting EMS Administrator
 Date: _____

TYPE OF COURSE

/ / EMD / / EMD Review
 / / EMT / / EMT Review
 / / AEMT / / AEMT Review

COURSE DATE:

From: _____ To: _____

COMMENTS:

Please Type or Print (Use Black or blue ink ONLY)

<p>Requested By (Print Full Name): _____ Position/Title: _____ SIGNATURE: _____</p>	<p>Sponsoring Agency: _____ Course Title: _____ Course Number: _____ Number of Hours: _____</p>
<p>Course Coordinator (Print Full Name): _____ SIGNATURE: _____</p>	<p align="center">Meets U.S. DOT/NHTSA Training Standards: / / Yes / / No</p>
<p>PRIMARY Lead Instructor (Print Full Name): _____ SIGNATURE: _____</p>	<p align="center">Number of Students (maximum – 24): _____</p>
<p>SECONDARY Lead Instructor (Print Full Name): _____ SIGNATURE: _____</p>	<p>Instructor Aide (Print Full Name): _____ SIGNATURE: _____</p>

COURSE APPROVAL REQUEST

Please attach the following documentation with this request. Documentation must be submitted one (1) month prior to review and approval with two copies (original and two copies):

1. **COURSE SCHEDULE:** The schedule must include the dates, times, topics, lab schedules, quizzes, exams, as well as proposed commencement and completion dates for each course.
2. **Training Objectives and Methodology**
3. **Course Outline**
4. **Documentation of sufficient and type of instructor materials.** Documentation must include the name of the Instructor manual, resource materials, TV, VCR, videos, etc.
5. **Type of Skills Manual to be used.** A skills manual is highly recommended as a supplemental to the test
6. **Textbooks and reference materials**
7. **Examination requirements**
8. **Equipment required.** Documentation of your ability to maintain and acquire, if necessary, the equipment, materials and supplies necessary to conduct the course
9. **A list of CERTIFIED Course Instructors**
10. **A copy of Memorandum of Agreement with the medical facility that will be providing the hospital clinical experience**
11. **Copies of ALL quizzes and exams**
12. **A final skills exam checklist.** The checklist must include detailed steps and measurable outcome, as this practical exam is used in lieu of the skills practical for the Guam Exam.

Course Director (Print Full Name):

Signature: _____

Title: _____

Contact Number: _____

Sponsoring Dept/Agency Head (Print Full Name):

Signature: _____

Title: _____

Contact Number: _____

NOTE

If the training institution / sponsoring department cannot fill their own Medical Director position then the DPHSS-EMS Medical Director will serve as the Acting Medical Director to ensure oversight for the EMT Course.

DPHSS-EMS Office Medical Director (Print Full Name):

Signature: _____

Date: _____

Dept/Agency Medical Director (Print Full Name):

Signature: _____

Date: _____