

## EDUCATIONAL INSTITUTE ENDORSEMENT

### -RECERTIFICATION-

Please print or type.  
The application must be fully  
completed to be considered.  
Submit completed application  
to the **WVOEMS Education  
Coordinator**

### Institution Information

Name:			
Address	City	State	Zip
Phone Number:	Email Address:		
Fax Number:			

### Administrative Director

Name:		Title:	
Address	City	State	Zip
Phone Number:	Email Address:		
Cell Number:			

### Medical Director

Name:		Title:	
Address	City	State	Zip
Phone Number:	Email Address:		
Cell Number:			

### Credential Application

Endorsement Level (Check all that apply): BLS ☐ ALS ☐ CCT ☐ Sponsor of Continuing Education ☐

Education Programs to be Conducted	Courses	Initial	Recertification	CE
	BLS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	EMR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	EMT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	AEMT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Paramedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	CCT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Recertification

Endorsement Level (Check all that apply): BLS ☐ ALS ☐ CCT ☐ Sponsor of Continuing Education ☐

SPONSOR OF CONTINUING EDUCATION  <i>Recertification requirements for <b>Sponsors of Continuing Education</b> requires proof of ten (10) educational courses. List the WVOEMS approval numbers and dates for proof of completion. If courses are on the pre-approved list, simply list the course name and date.</i>	Course Numbers/Name	Date	Course Numbers/Name	Date

BLS and CCT INSTITUTES	WVOEMS Course Numbers	Date	Cumulative Score %
<i>Proof of three (3) WVOEMS approved educational courses with a cumulative sixty (60) percent completion rate for initially enrolled students</i>			

**\*\* Educational Institutes are required to attach a list of credentialed instructors that identifies role, instructor level, and expiration date.**

# Signatures

*The signatures below certify that the information is true and complete. If information is found to be inaccurate, an audit will be ordered.*

Administrative Director:	Date:
Medical Director:	Date: