EDUCATIONAL INSTITUTE ENDORSEMENT APPLICATION -INITIAL-

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:

Fax Number:

Email Address:

Administrative Director

Name: | Title:

Address	City	State	Zip

Phone Number:

Cell Number:

Email Address:

Medical Director

Name: | Title:

Address	City	State	Zip

Phone Number:

Cell Number:

Email Address:

Credential Application

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

CCT requires affiliation with a postsecondary institute: ______________________________

Education Programs to be Conducted

Courses	Initial	Recertification	CE
BLS	☐	☐	☐
EMR	☐	☐	☐
EMT	☐	☐	☐
AEMT	☐	☐	☐
Paramedic	☐	☐	☐
CCT	☐	☐	☐

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: