SACRAMENTO COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF EMERGENCY MEDICAL SERVICES
EMT-I TRAINING PROGRAM
2A. PROGRAM DIRECTOR

(If same as Clinical Coordinator complete name only.)

Name:

Address:

Phone: ( )

Occupation:

Present Employer:

Professional and/or Academic Degree(s) currently held:

Professional License Number(s) (must be current and State of California):

Expires:

Expires:

Expires:

Expires:

Expires:

Emergency Care - Related Experience (showing two applicable years in the past five):

Position	Responsibilities	Institution	Dates
(attach resume)			
1.			
2.			
3.			

Emergency Care - Related Education (within the past two years):

Course Title	School	Course Length	Completion Date
1.			
2.			
3.			

What California teaching credential(s) do you now hold, if any?

Type:

Expiration Date:

The principle instructor is required to teach no less than 50% of the didactic classroom hours (Title 22 CCR § 100071).

Signature/Date:

_____

Program Director

02/07/06