



FOR OFFICIAL USE ONLY
 CLASSIFICATION _____
 CERT. NUMBER _____
 DATE ISSUED _____

State of West Virginia

WV Office of Miners' Health, Safety & Training
 Eugene White, Director
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EMERGENCY MEDICAL TECHNICIAN-M AND INSTRUCTOR APPLICATION

<u>Type of Application (Check all that apply)</u>		
<input type="checkbox"/> EMT-Miner 60 Hour <input type="checkbox"/> Grandfathered	<input type="checkbox"/> EMT-Miner Recertification <input type="checkbox"/> 8 Hour <input type="checkbox"/> 32 Hour	<input type="checkbox"/> EMT-M Instructor <input type="checkbox"/> EMT-M Reciprocity
Last Name:	First:	MI:
DOB:	SSN:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Phone (H):	Phone (C):	Email:
Mailing Address:	City/County:	State/Zip:

- **Initial** applicants for EMT-M certification must show verification of current CPR Certification.
- When **recertifying** as an EMT-M the applicant must submit verification of current CPR certification.
- **EMT-M Instructors** must submit documentation of their certification or qualification as a first aid instructor and verification that they are a current **CPR Instructor**.
- When requesting **reciprocity** as an EMT-M, you must attach all documentation verifying your training, certification (if applicable) and experience in the medical field.

Failure to fully and truthfully complete this application will result in your application being rejected or certification delayed or refused.

I swear or affirm that I meet all requirements for certification as an EMT-Miner or EMT-M Instructor and do hereby swear or affirm the information given on this application is true and correct.

Applicants Signature: _____ **Date:** _____

FOR OFFICIAL USE ONLY		Written Exam Score _____	
Practical Exam:	Patient Assess/Mgmt Medical <input type="checkbox"/>	Patient Assess/Mgmt Trauma <input type="checkbox"/>	Cardiac / AED <input type="checkbox"/>
		Baseline – Vitals <input type="checkbox"/>	Airway Mgmt <input type="checkbox"/>
Bleeding Ctrl/Shock Mgmt <input type="checkbox"/>	Immobilization – Extremities <input type="checkbox"/>	Immobilization – Seated (KED) <input type="checkbox"/>	Immobilization – Seated Supine <input type="checkbox"/>
		Immobilization – Traction Splint <input type="checkbox"/>	

WV OFFICE OF MINERS' HEALTH, SAFETY & TRAINING

STUDENT ROSTER

Instructor: _____ CPR Inst. Exp. Date: _____ Phone Number: _____

Directions: _____

Please mark appropriate box: **Initial Roster** (Must include instructor's contact information and directions to the training facility)
 Final Roster (Must include individuals who have successfully completed the course)

Number Enrolled: _____ Initial EMT-M Course: _____ Retraining Module: 1 2 3 4

	Student's Last Name	Student's First Name	Mailing Address	Last 4 SSN
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

I verify that persons on this final roster have successfully completed the cognitive and skills evaluation in the above listed courses.

Signature of Instructor: _____

Course Date(s): _____

Region One: 14 Commerce Dr., Suite 1 - Westover, West Virginia 26501 Telephone: 304-285-3268 Fax: 304-285-3275
Region Two: 830 Virginia Ave. - Welch, West Virginia 24801 Telephone: 304-436-8421 Fax: 304-436-2100
Region Three: 431 Running Right Way - Julian, West Virginia 25529 Telephone: 304-369-7823 Fax: 304-369-7826
Region Four: 337 Industrial Drive - Oak Hill, West Virginia 25901 Telephone: 304-469-8100 Fax: 304-469-4059