State Of Delaware
Office of Emergency Medical Services

Application for Continuing Education Credit

Presenting Agency and Address:

Agency Contact:

Contact Phone:

Contact Email:

Fax:

Program Name and Brief Description:

Content	Hrs
❑ Patient Assessment	___
❑ Airway, Breathing & Cardiology	___
❑ Medical Emergencies	___
❑ Trauma	___
❑ Obstetrics & Pediatrics	___
❑ Operational Tasks	___
❑ Preparatory	___

Course Location:

Total Hours:
BLS: ____ ALS ____

Class Start Date:

Class End Date:

Name of Primary Instructor and Credentials:

Class Times:

Signature of Agency Contact:

Date:

Name of Course Medical Director and Credentials:

Please attach the following:
1) **Course Objectives**
2) **Course Outline (include instructional hours per section)**
3) **Post-Course Evaluation Tool (quiz, test, skill evaluation tool, class evaluation)**
4) **Example, Course Completion Certificate**

OEMS Use Only Below This Line

Received by OEMS (Initial/Date):

Reviewed By: (Initial/Date):

Medical Director Review:

Date:

Status:
- ❑ Approved
- ❑ Approved w/ Comments
- ❑ Not Approved w/ Comments

Approval Number:

- CED -

Comments:

Date Approved:

Core Content:
- ❑ Mandatory
- ❑ Flexible
- ❑ Elective

Approved Credit Hours:
BLS: ____ ALS ____