Semi-Annual Report Form
For ALS Technicians

Name _____ Cert # _____ Agency ____

Report for the 6 months ending: June December Year _____

Level of Certification: E I P

Please use incident number or date and signature of technician observing the skill. You may record additional items on the back of this form.

ET's
(Minimum 6 in 6 months: /E - Adults only; /I/P – Adult & Pediatric)

1.	4.
2.	5.
3.	6.

IO's
(Minimum 2 each adult & Peds. in 6 months)

1.	2.
1.	2.

Surgical Cricothyrotomy
(Minimum 1 in 6 months)

1.

Chest Decompression
(Minimum 1 in 6 months)

1.

Continuous Positive Airway Pressure Setup
(Minimum 1 in 6 months)

1

I certify that the above is accurate.

Technician's Signature Date

Chief's Signature Date

Appendix "C"

Revised 03/2010