# STATE OF FLORIDA DEPARTMENT OF HEALTH

**BUREAU OF EMERGENCY MEDICAL OVERSIGHT CERTIFICATION OF TRAINING**

I , as medical director of

 , a Florida licensed EMS provider, hereby verify that the following paramedics have been trained to administer immunizations in

accordance with the requirements of Section 401.272(2)(b), Florida Statutes and 64J-1.004(5) Florida Administrative Code:

Name Certification Number

1.

2.

3.

4.

5.

6.

7.

Signature

Florida Medical License number

STATE OF FLORIDA

COUNTY OF

Sworn to (or affirmed) and subscribed before me this day of , 20 , by . Personally Known OR Produced Identification Type of Identification.

Signature of Notary

(Seal) My Commission Expires

**DH 1256, 12/08**