# Department of Health Medical Quality Assurance

**ELIGIBILITY ROSTER FOR EMS CERTIFICATION**

|  |  |  |
| --- | --- | --- |
| Name of Training Program |  | Training Program Code Number |
| Street Address |  | Phone Number |
| City | County | Zip Code |
| Name of Program Director | Beginning Date | Ending Date |
| Program Type (EMT, Paramedic) |  | Total Clock Hours |

INSTRUCTIONS:

In alphabetical order type or print, the names of students that have successfully completed the training program identified above. (Use another roster if needed)

Roster(s) shall be emailed within 14 days of course completion to the Division of Medical Quality Assurance, EMT/Paramedic Certification Unit at: MQA.EMSSchoolLists@flhealth.gov

Last Name First Name Middle Initial DOB or Last 4 of SNN

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Last Name First Name Middle Initial DOB or Last 4 of SNN

11.

12.

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20.

I affirm that the students listed above, have successfully completed the training program, and have current CPR or ACLS certification or its equivalent as applicable.

Program Director Signature Date