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.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
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