



# TEXAS DEPARTMENT OF STATE HEALTH SERVICES

DAVID L. LAKEY, M.D.  
COMMISSIONER

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## SKILLS PROFICIENCY FORM

All information given on this form is considered public record, with exception of social security number\*. Candidate should submit this form with the recertification application. Successful completion of skills proficiency verification must be within 6 months of recertification application date.

Basic Skills Proficiency Verification for ECA shall consist of:

Bandaging and Splinting    Mechanical Aids to Breath    Spinal Immobilization  
Traction Splinting    Physical Assessment of Patient    CPR

IN ADDITION TO THE ABOVE, EMT (1994 Curriculum) Skills Proficiency Verification shall consist of:

Epinephrine Auto-Injector    Bronchodilator Administration  
Cardiac Arrest Management/AED    Pneumatic Anti-shock Garment (PASG)

IN ADDITION TO THE ABOVE, EMT-I Skills Proficiency Verification shall consist of:

Peripheral Venipuncture    Adult Endotracheal Intubation  
Esophageal Intubation    Infant Endotracheal Intubation

IN ADDITION TO THE ABOVE, EMT-P Skills Proficiency Verification shall consist of:

Drug Administration    Defibrillation/Cardioversion    Megacode

\_\_\_\_\_  
Print Candidate's Last Name

\_\_\_\_\_  
First

\_\_\_\_\_  
SS# or EMS ID#

\* \* \* **TO BE FILLED OUT BY A TEXAS CERTIFIED EMS COORDINATOR** \* \* \*

I verify that the proficiency of the candidate has been examined and verified as competent in the application of all required skills.

I understand that by signing this document I am attesting that all of the information on this document is true and correct. I also understand that the DSHS will take action against my EMS certification(s) if the information submitted is found to have been falsified.

**EMS Coordinator Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Coordinator Last Name, First Name, M.I.:** \_\_\_\_\_

**Coordinator EMS ID No.:** \_\_\_\_\_

**Program Telephone No.:** \_\_\_\_\_ **Program Fax No.:** \_\_\_\_\_

(Revised 3/23/07)