Candidate Optional Module Examination Registration Form

E-Mail the completed form to EMSCourses@dhw.idaho.gov
Or Fax the completed form to 208-334-4015 Questions? – call 208-334-4000 or 1-877-554-3367

Name: Social Security Number: Date of Birth:

Address:

E-mail Address: Telephone Number:

Selected Examination: Location: Date:

	Exam Results (For Bureau Use Only)				
	First Attempt			Retest	
Skills to be Tested (check all that apply):	**PASS**	**FAIL**		**PASS**	**FAIL**
☐ Spinal Immobilization Supine (EMR)	❑	❑		❑	❑
☐ Spinal Immobilization Seated (EMR)	❑	❑		❑	❑
☐ Extremity Splinting: Long Bone or Joint (EMR)	❑	❑		❑	❑
☐ Supraglottic Airway Device (EMT)	❑	❑		❑	❑
☐ Intravenous Therapy (EMT)	❑	❑		❑	❑
☐ Intraosseous Infusion (EMT)	❑	❑		❑	❑
	Exam Administrator's Signature			Exam Date	

Medical Director Approval:
As medical director for _____ (licensed EMS agency), I have verified the candidate applying for this exam has successfully completed all didactic, lab and clinical training for the optional skills according to the approved curriculum as required by the Idaho Bureau of EMS and Preparedness.

_____ _____ _____
Medical Director Signature Medical Director (printed name) Date

Candidate Statement:
I agree to abide by all Bureau policies in the administration of the optional module skill examination and agree to release my results to the medical director authorizing my exams.

_____ _____
Candidate Signature Date

Date Received

Data Entry