Office of EMS and Trauma Provider Service Protocol Update Completion Roster

Provider Service Full Name: _____

County: _____

Region: _____

ID#: _____

Completion Date: _____

Provider Service Off-Line Medical Director Name: _____

Individuals not completing the 20___ Protocol Updates must be removed from the service roster and are not allowed to work until such time as the 20___ Protocol Updates have been completed.

	Name on AL License	Level B/I/P	AL EMT License #
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This form is for Regional Validation Only!!
When the Protocol Updates have been completed, forward this roster and addition to your Regional EMS Agency.

I hereby attest that the above listed individuals have completed all protocol updates as required by the Office of EMS & Trauma in the Alabama Department of Public Health.

Signature: _____