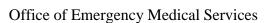


STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH





PARAMEDIC LICENSURE VERIFICATION OF PARAMEDIC TRAINING PROGRAM

*For all fields to work properly, please download form to computer and open with Adobe Acobat

TO BE COMPLETED BY EDUCATIONAL INSTITUTION ONLY

Student's Last Name:	First Name:	MI:	Maiden Name:
Date course of training completed:			
Dates of individual's attendance: From	n To		
Course Approval Number:			
Total numbers of hours completed at t			
Total numbers of hours completed at the stand that that this info Department of Public Health a correct to the best of my know Name of Course Coordinator:	ormation is subject to rev and that all of the statem ledge and belief.	view upon ents contai	request by the ned herein are tr
I understand that that this info Department of Public Health a correct to the best of my know	ormation is subject to rev and that all of the statem ledge and belief.	view upon i ents contai	request by the ned herein are tr
I understand that that this info Department of Public Health a correct to the best of my know Name of Course Coordinator:	ormation is subject to revend that all of the statemed ledge and belief. Title	view upon i	request by the ned herein are to

DEPARTMENT OF PUBLIC HEALTH
PARAMEDIC LICENSURE
410 CAPITOL AVE., **MS# 12EMS**P.O. BOX 340308
HARTFORD, CT 06134-0308
860-509-7975 x1 (o)