# Greene County EMS System Scope of Practice/Skills/Oral Exam Personnel Verification Form

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**LEVEL:** **EMT** **AEMT** **PARAMEDIC** **EMD** **(Circle one)**

**TYPE:** **Initial** **Re-credential/Re-entry** **New to Greene County** **Suspension release**

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Name: ______________________________________________

Last First Middle

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**SECTION I:**
I verify that the above-named candidate is affiliated on a continuous basis with the above named North Carolina licensed ambulance provider or EMD center.

**Date** **Signature of Ranking Officer**

**First Responder Agency Affiliation** **(Please Print) Name/Title of ranking officer**

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**SECTION II:**
I verify that the above-named candidate has successfully completed a performance evaluation conducted under my direction and has demonstrated, to my satisfaction, his/her ability to perform the skills and procedures consistent with the level of care.

**Signature of Medical Director**

**Date** **Name of Medical Director (Please Print)**

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**SECTION III:**
This will verify that the Oral/Skills Review panel has examined the above-named candidate on this date. We, the undersigned, recommend that he/she be credentialed at the level consistent with the level of care tested.

**Signature of Second Panel Member** **Date**

**Name & Title of Second Panel Member (Please print)**