

Emergency Medical Responder  
**TRAINING AND TESTING VERIFICATION FORM**

**DO NOT FAX**

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**EXAMINEE INFORMATION**

Date of birth: \_\_\_\_\_  
Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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**EXAMINEE TRAINING INFORMATION**

Date Examinee completed  
the EMR training program: \_\_\_\_/\_\_\_\_/\_\_\_\_ | Training Program Code: \_\_\_\_\_ OK

▶ **(Approved Training Programs ONLY)**

Training Program Name: \_\_\_\_\_

▶ **(Ambulance Services, Emergency Medical Response Agencies and Fire Service Training Program)**

If the Training Program Code is 888 or 510, give the location of this class:

\_\_\_\_\_

Course Authorization Number [CAN]: \_\_\_\_\_

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**TRAINING VERIFICATION STATEMENT**

*I verify that the above named student has passed the Emergency Medical Responder (First Responder) curriculum and final practical examination within the past 24 months and that the training is currently approved by the Oklahoma State Department of Health - Emergency Medical Services Division.*

\_\_\_\_\_  
Instructor Printed Name

\_\_\_\_\_  
Instructor Signature

\_\_\_\_\_  
Instructor Telephone Number

\_\_\_\_\_  
Date

NOTES: \_\_\_\_\_  
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**THIS APPLICATION IS NOT VALID WITHOUT WRITTEN EXAMINATION RECORD [on back]**



Oklahoma  
State  
Department  
of Health

