National Registry of
Emergency Medical Technicians®
THE NATION'S EMS CERTIFICATION™

EMT Psychomotor Examination Verification

Candidate Name _____ Application Confirmation Number _____

Address _____ City _____ State _____ Zip _____

Email _____ Phone Number _____

To Be Completed by the Instructor, Training Officer or EMS Service Director:

I verify that _____ (candidate name) has completed a state-approved psychomotor examination equal to or exceeding the criteria established by the NREMT and performed satisfactorily so as to be deemed competent in the following skills:

- Patient Assessment/Management – Medical
- Patient Assessment/Management – Trauma
- Bag Valve – Mask (Apneic Adult Patient)
- Oxygen Administration by Non-rebreather Mask
- Cardiac Arrest Management/AED
- Spinal Immobilization (Supine Patient)
- Random Skill Verification _____

Psychomotor Exam Location _____ Psychomotor Exam Date _____

Name (print) _____ Title _____

Signature _____ Date _____

I hereby affirm that all statements on the EMT Psychomotor Examination Verification are true and correct. It is understood that false statements may be sufficient cause for revocation by the NREMT. It is also understood that NREMT may conduct an audit of the activities listed at any time.

Candidate Signature _____ Date _____