



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
Division of Emergency Medical Services  
Heritage Place, Metro Center  
227 French Landing, Suite 303  
Nashville, Tennessee 37243  
Phone: 615-741-2584  
Fax: 615-741-4217

**CRITICAL CARE PARAMEDIC  
INSTITUTION TRAINING  
APPLICATION**

*Complete and return to the Tennessee Department of Health Division of Emergency Services*

**1. Institution Information:**

Name Sponsoring Institution

Address

City/State/Zip

Voice

Fax

Email

**Sponsor (s) Include:**

- Community College
- University
- Medical School
- Hospital
- Other

**2. Philosophy, Purpose, Capabilities and Organization**

(All facilities, institutions, or agencies seeking initial and continuing approval shall have a written statement of the educational philosophy and purpose of the program).

**3. Organizational Support**

The facilities, institutions, or agencies shall demonstrate effective organization and shall be administered in ways conducive to the management of training programs.

**College/University President or Chief Administrative Officer**

Name

Title

Address

City/State/Zip

Voice

Fax

Email

**Dean or comparable Administrative Officer**

Name

Title

Address

City/State/Zip

Voice

Fax

Email

**Program Director**

Name

Title

Address

City/State/Zip

Voice

Fax

Email

Is the Program Director employed full-time by the sponsor?  Yes  No

**Clinical Coordinator ( if applicable)**

Name

Title

Address

City/State/Zip

Voice

Fax

Email

Is the clinical coordinator employed full-time by the sponsor?  Yes  No

**Medical Director:** Each program shall have a licensed physician who serves as the medical advisor

Name

Title

Address

City/State/Zip

Voice

Fax

Email

**Co Medical Director (if applicable)**

Name

Title

Address

City/State/Zip

Voice

Fax

Email

**4. Clinical Affiliation:**

(The facilities, institutions, or agencies shall maintain liaison with a hospital, which is capable of supporting Critical Care Paramedic Clinical training, The clinical facilities must provide for student learning experiences as identified in the Board approved curriculum.)

Name Clinical Affiliate

Address

City/State/Zip

Voice

**5. Financial Support:**

The facilities, institutions, or agencies shall ensure the financial support, which will provide for a sound educational program. (please make a statement concerning financial support and have copy of budget for review at time of site visit)

**6. Faculty**

The faculty shall be experienced in the field area for course content, such as, but not limited to, critical care professionals, attorneys, and Registered Respiratory Therapists.

**List Faculty to be utilized in course** (please make resumes available on each instructor of review during site visit)

**7. Student Admission:**

Each student must hold a current license as a Paramedic in Tennessee with a minimum of two years experience as an Advanced Care Provider; and, must hold current certification in an Advanced Cardiac Life Support, Pediatric Advanced Life Support, and an advanced Trauma Care course

**Admission policy for program.** (Please provide at time of site visit a copy of admission policy for program.)

**8. Training Facilities *Classrooms, Laboratories, Offices.***

Institutions, or agencies shall provide adequate teaching and laboratories facilities sufficient for instruction. Please describe teaching and laboratory facilities.

**9. Curriculum Review:**

A copy of the complete curriculum, statements of course objectives, copies of course outlines, class schedules, schedules of supervised clinical experience, and teaching plans shall be on file and available for review and inspections by an authorized representative of the EMS Division

**Curriculum, course schedule, clinical schedules and teaching plans shall be available for review at time of site visit.**

**10. Student Records**

An accurate, comprehensive records system shall be maintained for all phases of the program and shall be available for review and inspections by an authorized representative of the EMS Division. Evidence of student competency in achieving the performance of the educational objectives of the program shall be kept on file.

**Student evaluation tools utilized during the course will be reviewed at time of the site visit.**

**11. Program Evaluation**

Procedures for evaluation of teaching effectiveness and instruction shall be established

**Tools utilized to evaluation faculty and program will be reviewed at the time of the site visit.**

**12. Equipment:**

Ensure the equipment,; as identified in the Board approved curriculum in order to provide for student learning experiences that will provide for a sound educational program

**Equipment shall be made available for inspection at time of site visit.**

**13. Student Enrollment:**

**Projected date to begin first course**

**Projected date of end of first course.**

**14. Contact Person for Application if different from Program Director**

Name

Title

Address

City/State/Zip

Voice

Fax

Email

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**Signature and Title of Individual completing application**

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**Date**