



SCOPE OF PRACTICE DOCUMENTATION – ADVANCED EMT RED DOT SKILLS

This letter serves as specific written authorization of the EMS provider listed below for use of the procedures and medications as described when operating on behalf of the agency and physician signing.

PROVIDER _____

CERTIFICATION LEVEL / NUMBER _____

Procedure / Medication	Authorized	Date of Training
Non-Invasive Positive Pressure Ventilation	YES / NO	
	YES / NO	

Agency OMD _____ Date _____

Agency Representative / Agency _____ Date _____