



INLAND COUNTIES EMERGENCY MEDICAL AGENCY
Serving San Bernardino, Inyo, and Mono Counties
1425 SOUTH "D" STREET
SAN BERNARDINO, CA 92415-0060
909-388-5823 FAX: 909-388-5825

MOBILE INTENSIVE CARE NURSE COURSE RECORD

I. TRAINING PROVIDER NAME: _____ **COURSE NO:** _____

Location: _____ Date of Course Completion: _____

II. TYPE OF COURSE:

- Basic

 Challenge

 Written & Skills Exams ONLY
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III. TO BE COMPLETED BY PRINCIPAL INSTRUCTOR: I hereby certify that the persons whose names listed below are designated according to final class status (i.e. pass, fail, completed, dropped) and that these records concur with the records of the training institution. I also certify that individuals participating in the final/certifying examination did so after verification of completion of all modules of the course by my signature. I have informed the class of ICEMA's Certification Policies and have distributed the Certification Form to each student.

_____ Skills Examination Date

_____ Written Examination Date

_____ Principal Instructor Signature

_____ Date

IV. TO BE COMPLETED BY PROGRAM COURSE DIRECTOR OR DESIGNEE: I hereby certify that all persons listed below have completed the course and passed the final/certifying examination and was issued course completion records on:

_____ Date

_____ Program Course Director/Designee Signature

_____ Date

V. PRINT OR TYPE-LIST NAMES ALPHABETICALLY:

LAST	FIRST	SS#	ADDRESS	COURSE		EXAM	
				Co mpl ete	Inco mpl ete	Pass	Fail

Submit to ICEMA within fifteen (15) days after completion of the course.

