

INLAND COUNTIES EMERGENCY MEDICAL AGENCY



MOBILE INTENSIVE CARE NURSE (MICN) TRAINING PROGRAM APPROVAL PACKET

Serving Inyo, Mono and San Bernardino Counties



ICEMA

CHECK LIST FOR MICN TRAINING PROGRAM APPLICATION

MATERIALS TO BE SUBMITTED		PAGE NO.	ICEMA USE
1.	Statement of eligibility for program approval		
2.	Letter to ICEMA requesting approval		
3.	Completed Check List for MICN Program Approval		
4.	Application Form for Program Approval		
5.	Program Course Director Information Form		
6.	Medical Director Information Form		
7.	Principal Instructor Information Form		
8.	Teaching Assistant Information Form		
9.	Copy of written agreement with (1 or more) Acute Care Hospital(s) to provide clinical experience and/or		
10.	Copy of written agreement with 1 or more ambulance agency(ies) to provide field experience		
11.	Final written examination		
12.	Provisions for course completion by challenge		
13.	Location of courses offered and proposed dates		
14.	Table of Contents listing required information with corresponding page numbers.		

FORMS

COMPLETE AND RETURN WITH ICEMA APPLICATION & FEE

1. Application and fees
2. Teaching Staff Information (one for each):
 - Program Course Director
 - Medical Director
 - Principal Instructor
 - Teaching Assistant Information (one for each T.A.)

SUBMIT TO ICEMA AFTER COMPLETION OF EACH COURSE

ICEMA approved Course Record must be submitted within fifteen (15) days of course completion, typed or printed, and alphabetized.

ICEMA

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MATERIALS TO BE SUBMITTED		PAGE NO.	ICEMA USE ONLY
	COURSE DIRECTOR NAME:		
	Course Director Fact Sheet (signed)		
	Curriculum Vitae		
	Copies of RN License and MICN Certification		
	Copies of other Applicable Certifications		
	ACLS, BLS, TNCC, BTLS, PHTLS, PALS, ENPC, Other		
	Proof of Educational Requirement TYPE:		
	Attended EMS Orientation YES NO DATE:		
	Meets Requirements YES NO		
	MEDICAL DIRECTOR NAME:		
	Medical Director Fact Sheet (Signed)		
	Curriculum Vitae		
	Copy of MD License		
	Copies of other Applicable Certifications		
	ACLS, BLS, BTLS, ATLS, PALS, Other		
	Minimum two (2) years academic, administrative or clinical experience in emergency medicine or prehospital care within the last five (5) years.		
	Meet Requirements YES NO		
	APPLICATION		
	Program Application (signed)		
	Proposed Daily Schedule		
	Student Qualifications		
	Exam Passing Criteria		
	Retest Policy		
	Copy of Program Completion Record		
	Copy of Attendance Roster		
	Copy of Course Advertisement		
	PROGRAM CURRICULUM		
	Course Description		
	Lesson Plan		
	Materials/Equipment Needed		
	References		
	Student Handouts and Reference Material		
	Skill Sheets		
	Field Care Audit/Base Contact Simulations		
	Base form documentation with method of evaluation		
	Quizzes – with answer keys		
	Final Exam – with answer key		
	Course and Instructor Evaluation		
	QI PROGRAM		
	Program QI Plan		



INLAND COUNTIES EMERGENCY MEDICAL AGENCY
1425 SOUTH "D" STREET
SAN BERNARDINO, CA 92415-0060
909-388-5823 FAX: 909-388-5825

MICN TRAINING PROGRAM
APPLICATION FOR APPROVAL

PROVIDER NAME: _____

ADDRESS: _____

CITY/COUNTY/ZIP: _____

PROGRAM COURSE DIRECTOR: _____

PHONE: _____

EMAIL: _____

FAX: _____

MEDICAL DIRECTOR: _____

PHONE: _____

EMAIL: _____

FAX: _____

PRINCIPAL INSTRUCTOR: _____

PHONE: _____

EMAIL: _____

FAX: _____

Attach resumes of Program Course Director, Medical Director and Principal Instructors that demonstrates the individual's experience and qualifications in prehospital care/education. Include copies of all current licenses/certifications/accreditations. Submit the \$300.00 application fee. Fees are non-refundable and non-transferable.

I certify that I have read and understand the local policy for MICN Training Program Approval, and that I/this agency will comply with all guidelines, policies, and procedures described therein. I agree to comply with all audit and review provisions described. Furthermore, I certify that all information on this application, to the best of my knowledge, is true and correct.

 Signed, Program Director

 Date

(ICEMA Use Only)

Application Rec'd Date	Approval Date	Expiration Date	Receipt # Date Paid



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PROGRAM COURSE DIRECTOR INFORMATION

PROVIDER NAME: _____

ADDRESS: _____

CITY/COUNTY/ZIP: _____

PROGRAM COURSE DIRECTOR: _____

PHONE: _____

EMAIL: _____

FAX: _____

Attach Current Resume (Curriculum Vitae)

Eligibility Status (currently Certified/Licensed in the State of California, attach photocopy of all cards.)

	<u>License/Cert No.</u>	<u>Expiration Date</u>
<input type="checkbox"/> Physician	_____	_____
<input type="checkbox"/> Physician Assistant	_____	_____
<input type="checkbox"/> MICN	_____	_____
<input type="checkbox"/> RN	_____	_____
<input type="checkbox"/> EMT-P	_____	_____
<input type="checkbox"/> Other	_____	_____

-----**FOR ICEMA USE ONLY**-----

Approved: Yes No (If no, explain on a separate sheet and attach it.)

Approved by: _____ Date: _____



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MEDICAL DIRECTOR INFORMATION

PROVIDER NAME: _____

ADDRESS: _____

CITY/COUNTY/ZIP: _____

MEDICAL DIRECTOR: _____

PHONE: _____

EMAIL: _____

FAX: _____

Medical License Number: _____ **Expiration Date:** _____

Attach Current Resume (Curriculum Vitae)

MEDICAL DIRECTOR REQUIREMENTS AND FUNCTIONS:

The medical director monitors the overall quality of the program.

1. Medical director qualifications shall be based on the following:
 - a. Currently licensed and in good standing in the State of California as a physician.
 - b. Minimum of two (2) years academic, administrative, or clinical experience in emergency medicine or prehospital care within the last five (5) years.

2. The duties of the medical director shall include, but are not limited to:
 - a. Approving the instructor(s) in conjunction with the program course director.
 - b. Review and approve the educational content of the program curriculum and certify its ongoing appropriateness and medical accuracy.
 - c. Review and approve the quality of medical instruction, supervision, and evaluation.

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Approved: Yes No (If no, explain on a separate sheet and attach it.)

Approved by: _____ Date: _____



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PRINCIPAL INSTRUCTOR INFORMATION

COMPLETE ONE FORM FOR EACH INSTRUCTOR

PROVIDER NAME: _____

ADDRESS: _____

CITY/COUNTY/ZIP: _____

PRINCIPAL INSTRUCTOR: _____

PHONE: _____

EMAIL: _____

FAX: _____

Attach Current Resume (Curriculum Vitae)

Eligibility Status (currently Certified/Licensed in the State of California, attach photocopy of all cards.)

	<u>License/Cert No.</u>	<u>Expiration Date</u>
<input type="checkbox"/> Physician	_____	_____
<input type="checkbox"/> Physician Assistant	_____	_____
<input type="checkbox"/> MICN	_____	_____
<input type="checkbox"/> RN	_____	_____
<input type="checkbox"/> EMT-P	_____	_____
<input type="checkbox"/> Other	_____	_____

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Approved: Yes No (If no, explain on a separate sheet and attach it.)



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TEACHING ASSISTANT INFORMATION

PROVIDER NAME: _____

ADDRESS: _____

CITY/COUNTY/ZIP: _____

TEACHING ASSISTANT: _____

PHONE: _____

EMAIL: _____

FAX: _____

WORK EXPERIENCE RECORD MUST BE ATTACHED (Resume, Curriculum Vitae)

**List below those topics to which this Teaching Assistant is assigned and his/her qualifications and experience relative to same:

<u>Topic</u>	<u>Qualifications/Experience</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Approved By: _____
 Name (Program Course Director)

 Signature

-----**FOR ICEMA USE ONLY**-----

Approved: Yes No (If no, explain on a separate sheet and attach it.)

Approved by: _____ Date: _____



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NOTIFICATION OF PROPOSED COURSE

PROVIDER NAME: _____

Address: _____

Location of Instruction: _____

County: _____

Address (if different): _____

INSTRUCTOR: _____ Phone: _____

Email: _____

_____ Fee \$ _____
Course Starting Date

_____ Date of Written Exam
Course Completion Date

Submitted by: _____

Name (Program Course Director)

Signature

Date

***This notification should be submitted to ICEMA not less than thirty (30) days before the start of the course. The Program Course Director, Medical Director, Principal Instructor and Teaching Assistant Information Forms must either be on file at ICEMA or attached to this form prior to the start of the course. All instructors must be approved by ICEMA prior to the start of any course*