VERIFICATION OF COURSE COMPLETION

EMR, EMT, AEMT, Paramedic

MINNESOTA EMERGENCY MEDICAL SERVICES REGULATORY BOARD

Education Program Name:
Course Type:
Course Number: (Program Number-YY-MM-DD of Start Date)
Course Completion Date:

This roster is to be submitted upon completion of each course to emsrb@state.mn.us

ROSTER OF CANDIDATES THAT HAVE COMPLETED COURSE REQUIREMENTS

Last Name	First Name	EMSRB # (If applicable)	PASS

I certify all information provided on this verification of course completion roster is accurate. ☐

Education Program Coodinator:	Date:

SAVE FORM PRINT FORM EMAIL FORM