WREMAC PRECEPTOR APPLICATION

Name: ____

Mailing Address: ____

____

Home Phone #: ____

Cell Phone #: ____

Email Address: ____

EMT Certification #: ___________________________ Level of Care: ____________________________

Total # of yrs certified: ___________________ Total # of yrs at current level: _____________________

Current Instructor Credentials (CLI, CIC, CPR, ITLS, etc…): ______________________________________

All Current Agency Affiliations: ____

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Preceptor Course Taken: ____________________________________
(Date)

Given by: ____________________________________

I affirm that as a WREMAC Medical Director _____________________________ meets the requirements per description and qualification to be a WREMAC preceptor.

Medical Director:

Name:	Signature:	Title:	Date:

____

Registered with Program Agency: _______________
(Date)

Program Agency Notified WREMAC: _______________
(Date)