



## In-Service Training Program Application

| I. Official Use Only | Initial 2011 Program Start |  |
|----------------------|----------------------------|--|
|----------------------|----------------------------|--|

|                      |                 |  |
|----------------------|-----------------|--|
| Application Received | January - June  | Expiration 4 yrs from March 31 of current year |
| Application Received | July - December | Expiration 4 yrs from March 31 of next year    |

| II. | Type Application |
|-----|------------------|
|-----|------------------|

|  |  |
|--|--|
|  | Initial (Request for approval of first-time program OR program which was suspended or discontinued.) |
|  | Renewal (Renewal of current, on-going program for the next 4-year program cycle)                     |
|  | Change of Training Officer   |
|  | Change of Medical Control Physician (attach Medical Control Physician Form)                          |

| III. | EMS Provider Information |
|------|--------------------------|
|------|--------------------------|

|                        |                     |
|------------------------|---------------------|
| Primary Agency Name    | Agency SC License # |
| Agency Mailing Address |                     |
| City/State/Zip Code    | Phone #             |

| IV. | IST Primary Training Officer Information |
|-----|--|
|-----|--|

|   |              |              |         |
|---|--------------|--------------|---------|
| Name <i>(Person responsible for all administrative aspects of program.)</i> |              |              |         |
| Mailing Address   |              |              |         |
| City/State/Zip Code   |              |              |         |
| Home Phone #  | Work Phone # | Cell Phone # | Pager # |

| V. | EMS Providers Covered By Program |
|----|----------------------------------|
|----|----------------------------------|

| List All EMS Providers <i>(Include Primary Agency)</i> | Level of Training Covered by Program |       |      |           |
|--|--------------------------------------|-------|------|-----------|
| Agency Name  | SC License #                         | Basic | AEMT | Paramedic |
|  |                                      |       |      |           |
|  |                                      |       |      |           |
|  |                                      |       |      |           |
|  |                                      |       |      |           |
|  |                                      |       |      |           |

| VI. | Medical Control Endorsement |
|-----|-----------------------------|
|-----|-----------------------------|

Must be on file as Medical Control for ALL Agencies listed above.

|            |           |      |
|------------|-----------|------|
| Print Name | Signature | Date |
|------------|-----------|------|

*I have read, understood and will assure that the program complies with all guidelines as established by DHEC. I have attended or will attend a DHEC medical control workshop. I understand that I am NOT authorized to sign IST recertification documents until I have successfully completed an entire medical control workshop. I understand I must maintain my medical control status by completing any necessary recertification processes.*

**VII.**

**In-Service Training (IST) 2011 Option**

**Option 1:**

**Traditional Refresher Requirement  
(Must satisfy all refresher requirements every two years)**

|                        | <b>EMT-Basic</b> | <b>Intermediate I-85/AEMT</b> | <b>Paramedic</b> |
|------------------------|------------------|-------------------------------|------------------|
| <b>Topics</b>          | <b>Hours</b>     | <b>Hours</b>                  | <b>Hours</b>     |
| Preparatory            | 1                | 5                             | 6                |
| Airway Management      | 2                | 5                             | 6                |
| Trauma                 | 4                | 8                             | 10               |
| Medical                | 4                | 12                            | 18               |
| Special Considerations | 2                | 4                             | 6                |
| Operations             | 0                | 2                             | 2                |
| Patient Assessment     | 3                | 0                             | 0                |
| Electives              | 8                | 0                             | 0                |
| <b>Totals</b>          | <b>24</b>        | <b>36</b>                     | <b>48</b>        |

A Maximum of **10 hours** can be applied from Distributive Education toward refresher requirements and must be CECBEMS or DHEC approved.

*I verify that this IST program will provide the minimum of all required hours and topics in the Traditional Refresher course every two-years.*

\_\_\_\_\_  
Signature of IST Training Director and Date

**Option 2:**

**Refresher Requirement via National Standard Courses  
(Must satisfy all refresher requirements every two years)**

| Trauma Courses |
|----------------|
| ITLS           |
| PHTLS          |
| BTLS           |
| ATT            |

| Medical Courses |
|-----------------|
| AMLS            |
| EMPACKT         |

| Pediatric Courses |
|-------------------|
| EPC               |
| PEPP              |
| PALS              |
| PEARS             |
| NALS              |

| Other Courses |
|---------------|
| ACLS          |

*I verify that this IST program will provide the minimum of all required hours and topics in the Traditional Refresher course every two-years by using Nationally Recognized and Standardized Courses. Any topic not covered in these courses will be delivered in a traditional classroom format.*

\_\_\_\_\_  
Signature of IST Training Director and Date

**Option 3:**

If you plan to offer a combination of both options, please sign under both, Option 1 & Option 2