District of Columbia EMT Practical Examination Roster

Date: _____ Location: _____ Course Number: _____

Skill Station and Minimum Points Guide					
Mandatory Stations	**Time**	**Min/Max**	**Random Stations**	**Time**	**Min/Max**
1. Patient Assessment – Trauma	10	33/42	7a. Spinal Immobilization – Seated Patient	10	9/12
2. Patient Assessment – Medical	15	33/42	7b. Bleeding Control/Shock Management	10	5/7
3. B-V-M Apneic Patient	5	13/17	7c. Long Bone Immobilization	5	8/10
4. Oxygen Administration / NRB Mask	5	8/11	7d. Joint Injury	5	7/9
5. Cardiac Arrest Management / AED	10	14/18			
6. Spinal Immobilization – Supine Patient	10	11/14			

Name: (Last Name, First Name)		Phone or E-mail	Date of Birth	1	2	3	4	5	6	7 a	7 b	7 c	7 d	Overall Pass / Retest / Fail
1														
2														
3														
4														
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12														
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14														
15														

P=Pass, R=Retest, F=Fail

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Name: (Last Name, First Name)		Phone or E-mail	Date of Birth	1	2	3	4	5	6	7 a	7 b	7 c	7 d	Overall Pass / Retest / Fail
16														
17														
18														
19														
20														
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25														
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28														
29														
30														

P=Pass, R=Retest, F=Fail

I certify the results of the EMT Basic Practical Exam listed above to be accurate and true.

_____ _____ _____

Print Name – Examination Coordinator | Signature – Examination Coordinator | Date

_____ _____ _____

Print Name – District EMS Official | Signature – District EMS Official | Date

Course Number: _____