Name: _____ Certification Number _____

Certification Period: _____ - _____ Page _____ of _____

Iowa Department of Public Health

Bureau of EMS

Audit Reporting Form

(make copies as needed)

Formal

Title:		
Date	Sponsor Number:	Hours:
Title:		
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Optional

Title:		
Date	Authorized Sig or Sponsor Num:	Hours:
Title:		
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Date	Authorized Sig or Sponsor Num:	Hours:

Include documentation of current course completion in CPR (CPR, AED and obstructed airway for all age groups)

I hereby affirm that the information provided on this form is accurate. I understand that providing false or misleading information may result in a citation and warning, denial, probation, suspension or revocation of my EMS certification(s).

_____ _____

Signature Date