



# ADVANCED AIRWAY CHECK-OFF SHEET

PARAMEDIC/EMT SPECIALIST

DATE	PATIENT AGE/SEX	AIRWAY TYPE	NUMBER ATTEMPTS	COMMENTS

This is to certify that \_\_\_\_\_  
has successfully completed training in Advanced Airway Procedures.

\_\_\_\_\_ MD/CRNA (circle one)      DATE: \_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

ADDITIONAL COMMENTS


**PLEASE RETURN THIS FORM TO THE SAGINAW VALLEY MEDICAL CONTROL AUTHORITY**