

MONTANA BOARD OF MEDICAL EXAMINERS
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VERIFICATION FOR AEMT MEDICATION ENDORSEMENT

Student Name: _____ License Number: _____

I certify that the above named individual is competent in the following terminal objectives regarding the AEMT Medication Endorsement. The course or education was conducted according to Board policies and procedures, but this form **does not authorize practice.**

COGNITIVE OBJECTIVES

PSYCHOMOTOR OBJECTIVES

<p>List and describe medications which the AEMT may administer according to protocol. Discuss special consideration in regard to pregnant, pediatric and geriatric patients. List and describe general properties of the approved medications. List and describe liquid, solid, and gas drug forms of the approved medications. List and differentiate routes of approved medication administration to include IM, SQ, IN, IO, IV, PO and inhalation. Describe mechanisms of approved medications. Discuss considerations for storing the approved medications. Review the specific anatomy and physiology pertinent to the approved medication administration. Calculate drug dosages for the approved medications for adults, infants and children. Discuss legal aspects affecting medication administration. Discuss the "six rights" of drug administration and correlate these with the principles of medication administration. Discuss medical asepsis and the differences between clean and sterile techniques. Describe use of antiseptics and disinfectants. Describe the use of universal precautions and body substance isolation (BSI) procedures when administering a medication. Describe the indications, equipment needed, techniques utilized, precautions, and general principles for each of the approved medications.</p>	<p>Demonstrate universal precautions and body substance isolation (BSI) procedures during medication administration. Demonstrate clean technique during medication administration of all routes. Demonstrate preparation and administration of all approved medications Demonstrate disposal of contaminated items and sharps</p>
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Signature of Medical Director

PRINTED Name

Date

Montana Physician License Number