The Pre-Hospital Healthcare Team
for
Saginaw and Tuscola Counties

Office of the Medical Director
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ADVANCED AIRWAY CHECK-OFF SHEET

PARAMEDIC/ EMT SPECIALIST

Date	Patient Age/Sex	Airway Type	Number of Attempts	Comments

This is to certify that_____
has successfully completed training in Advanced Airway Procedures.

_____ MD/CRNA (circle one)
Printed Name

_____ Date_____
Signature

Additional Comments
