PREPARED FOR
PEDIATRICS
EMERGENCY MEDICAL SERVICES

PEDIATRIC READINESS RECOGNITION PROGRAM

EMS EDUCATION TRANSCRIPT

AGENCY NAME ______________________

Date ______________ Provider Name ______________________ Certificate # ______________

Class Name	Date Held	Hours Awarded
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Medical Director Name: ______________________ Signature: ______________________

My signature verifies that the Disaster Readiness Activities documented in this report are accurate and true.

PENNSYLVANIA
EMSC State Partnership Program
www.pehsc.org

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