



**ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
BUREAU OF EMERGENCY MEDICAL SERVICES &
TRAUMA SYSTEM
COURSE ROSTER**



Official

Addendum

Program Name: _____ Certificate Number: _____

Course Name: _____ Course ID Number _____

Course Location: _____

Course Start Date: _____ Course End Date: _____ Completion Date _____
(If other than end date)

Program Director: _____ Lead Instructor: _____

Medical Director: _____

	Name	Home Address	Social Security Number	Cert. No. Exp. Date	Final Score
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

Course Roster Continued

	Name	Home Address	Social Security Number	Cert. No. Exp. Date	Final Score
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					
26.					
27.					
28.					
29.					
30.					
31.					
32.					

I attest that the students listed on this course roster have met all course requirements in A.R.S. Title 36, Chapter 21.1 and Title 9, A.A.C. Chapter 25 and that all information submitted is true and accurate.

Signature or electronic signature of the Program Director: _____

Date of signature or electronic signature: _____