EMERGENCY MEDICAL
SERVICES AGENCY
LOS ANGELES COUNTY

Validation Checklist
<u>1:1 ALS Program Orientation / Competencies</u>
<u>Assisting with Defibrillation</u>

NAME: _____   ID# _____
(Please Print)

JOB POSITION: _____ INITIAL: ☐ RENEWAL: ☐ DATE: _____

PROCEDURE			
Performance Criteria	**YES**	**NO**	**Comments**
Identify patients in cardiac arrest or in need of electrical therapy intervention. Perform one person CPR and ventilations via BVM as needed for cardiac arrest victims			
Locate the monitor/defibrillator, pacing/defibrillator pads/patches and "hands free" cable. Connect to patient appropriately (follow manufacturer illustrations on pads if available)			
Verbalize understanding of safety precautions to be observed when the paramedic is defibrillating. (clear yourself and BVM from any contact with patient)			
Resume CPR in cardiac arrest patients immediately after shock.			

Validator Attestation Statement: *My signature below indicates that I have reviewed/validated each line item and that completion by the employee occurred on the date stated at the top of this document.*

VALIDATOR NAME / SIGNATURE: _____   DATE: _____
(Print Name & Sign)

☐   I understand the content and have completed the above competency assessment and verification process. I believe that I am a competent provider of this service as a result of training, experience and / or competency verification.

☐   I understand that I have not met the criteria needed to verify that I am competent provider of this service. I agree to participate in additional leaning activities as assigned in order to meet criteria.

■   I also understand that this form will be kept in my education file and is available upon request.

EMPLOYEE SIGNATURE: _____   DATE: _____

Revised 1/15/2020