



**Delegation of Authority**  
 from a Medical Advisor to a Health Region  
 to a Qualified Instructor to Conduct Specific ALS Skills Assessments

I, \_\_\_\_\_, am a Medical Advisor to the \_\_\_\_\_ Health Region  
[Print Full Name]  [Print Name of Health Region]

appointed by \_\_\_\_\_ for the period \_\_\_\_\_ to \_\_\_\_\_.  
[EMS Director]  [Date]  [Date]

\_\_\_\_\_, a practicing EMT-Paramedic registered with the Saskatchewan  
[Print Name of Instructor]

College of Paramedics (SCoP), registry number \_\_\_\_\_, has shown me his SCoP member card  
[6 digit SCoP Number]

and provided me with copies of the following current, valid instructor certificates:

Certificate	Instructor Number	Expiry Date
<input type="checkbox"/> ITLS Advanced		
<input type="checkbox"/> ACLS		
<input type="checkbox"/> PALS		
<input type="checkbox"/> PEPP Advanced		

I have observed him/her conducting ALS skills assessments of emergency medical practitioners in Saskatchewan. I hereby authorize \_\_\_\_\_ to conduct the following ALS  
[Print Name of Instructor]

skills assessments in 2009 and 2010 for recertification with the Saskatchewan College of Paramedics:

- |                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                           |                                                                                                                                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>ITLS Advanced</b> <ul style="list-style-type: none"> <li>• 3 Airway Adjuncts:           <ul style="list-style-type: none"> <li>○ King</li> <li>○ LMA</li> <li>○ Combi-tube</li> </ul> </li> <li>• Intubation</li> <li>• Intraosseous infusion</li> <li>• Chest decompression</li> <li>• External jugular vein cannulization</li> </ul> | <input type="checkbox"/> <b>ACLS</b> <ul style="list-style-type: none"> <li>• Cardioversion</li> <li>• Vagal manouevers</li> <li>• Transcutaneous pacing</li> <li>• Intubation</li> </ul> | <input type="checkbox"/> <b>PALS/PEPP Advanced</b> <ul style="list-style-type: none"> <li>• Pediatric intraosseous infusion</li> <li>• Pediatric intubation</li> <li>• Pediatric cardioversion</li> </ul> |
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\_\_\_\_\_  
[Signature of Medical Advisor]

\_\_\_\_\_  
[Date]

\_\_\_\_\_  
[Phone Number]