



REGION X EMS

Advanced Life Support

SKILL VALIDATION SHEETS

Psychomotor Competency Check-Off Forms

Derived from Region X Standard Operating Procedures, Version 202505.1 (Effective May 26, 2025)



Skills Included

1. 12-Lead ECG (Paramedic)
2. Amputated and Avulsed Parts (EMR / EMT / Paramedic)
3. Cricothyrotomy – Needle (Paramedic)
4. Cricothyrotomy – Surgical (Paramedic)
5. I-GEL Airway (Per System scope of practice)
6. Intraosseous Infusion – EZ-IO® (Paramedic)
7. Needle Decompression, Chest (Paramedic)
8. Spinal Motion Restriction (SMR) (EMR / EMT / Paramedic)
9. Synchronized Cardioversion (Paramedic)
10. Tarp Assisted Cooling with Oscillation (TACO Method) (EMR / EMT / Paramedic)
11. Tourniquet Use (EMR / EMT / Paramedic)
12. Transcutaneous Pacing (Paramedic)

12-Lead ECGScope of practice: **Paramedic**

SOP Revised 5/7/2024

Candidate		Date	
Evaluator		Provider Level	
Agency / ID		Attempt #	

Indications**Indicated for:**

- Discomfort/Pain: chest, jaw, neck, shoulder, arm, back, epigastric
- Anginal equivalent / atypical presentation: SOB, diaphoresis, dizziness, fatigue, weakness, syncope, nausea, vomiting, palpitations
- PMH and risk factors: age, diabetes, heart failure, high cholesterol, hypertension, previous MI, smoking

Performance Steps

#	Performance Step	Successful	Unsuccessful
1	Recognize indications/considerations for 12-lead acquisition (anginal pain, anginal equivalent, PMH/risk factors).	☐	☐
2	Prepare patient: expose chest, prep skin as needed for adequate electrode adhesion (dry, shave, abrade as required).	☐	☐
3	Apply limb leads in correct positions.	☐	☐
4	Apply precordial (chest) leads in correct anatomic positions: – V1: 4th intercostal space, right of sternum – V2: 4th intercostal space, left of sternum – V3: midway between V2 & V4 – V4: 5th intercostal space, midclavicular – V5: midway between V4 & V6 – V6: 5th intercostal space, midaxillary	☐	☐
5	Minimize artifact (patient still, secure contact) and acquire the 12-lead ECG.	☐	☐
6	Interpret the 12-lead, identifying ischemia / injury / infarction criteria: – Ischemia: hyperacute T waves, T wave inversion, ST depression – Injury: ST elevation > 1 mm in 2 or more contiguous leads – Infarction: injury ST elevation and reciprocal changes, deep wide Q waves	☐	☐
7	Localize the MI by territory using the lead/ST-change reference (lateral, inferior, septal, anterior, posterior).	☐	☐
8	If ST elevation in inferior leads (II, III, aVF), obtain a right-sided 12-lead (move V4 to right midclavicular / V4R) to evaluate right ventricular involvement (RV involvement if ST elevation > 1 mm in V4R).	☐	☐
9	Transmit the 12-lead to the receiving facility and continue cardiac monitoring.	☐	☐
10	Document acquisition, interpretation, and transmission in the patient care report.	☐	☐

Reference Charts**MI Localization Reference**

MI Location	ST Elevation	ST Depression
Lateral	I, aVL, V5, V6	II, III, aVF
Inferior	II, III, aVF	I, aVL, V5, V6
Septal	V1, V2	None
Anterior	V3, V4	None

MI Location	ST Elevation	ST Depression
Posterior	None	V1, V2, V3, V4

Notes / Critical Criteria

- Right-sided placement (V4R) is indicated for ST elevation in the inferior leads (II, III, aVF), which suggests Right Coronary Artery blockage; moving V4 to the right chest evaluates for right ventricular injury/infarction.

Evaluation Result

Result	☐ PASS / Competent ☐ Needs Remediation	Date	
Comments			
Evaluator Signature			

Amputated and Avulsed PartsScope of practice: **EMR / EMT / Paramedic**

SOP p. 87

Candidate		Date	
Evaluator		Provider Level	
Agency / ID		Attempt #	

Performance Steps

#	Performance Step	Successful	Unsuccessful
1	Initiate Adult/Pediatric Routine Trauma Care.	☐	☐
2	If gross contamination, gently rinse stump and amputated part with NORMAL SALINE.	☐	☐
3	Control bleeding with direct pressure. Utilize hemostatic gauze if available. If needed, apply a tourniquet.	☐	☐
4	Cover stump with sterile NS-moistened dressing, additional sterile dressing, and wrap with elastic bandage (ACE wrap) providing uniform pressure over the entire stump.	☐	☐
5	Care for the amputated part: – A. In case of incomplete amputation, splint in physiologic position. – B. Wrap part in NS-moistened gauze and place in a plastic bag/container. – C. Place bag/container inside a larger bag or container with cold packs or ice and water. – D. Do NOT allow parts to come in direct contact with ice/cold packs or submerge in NS.	☐	☐
6	Transport amputated part with the patient for possible re-implantation.	☐	☐

Evaluation Result

Result	☐ PASS / Competent ☐ Needs Remediation	Date	
Comments			
Evaluator Signature			

Cricothyrotomy – NeedleScope of practice: **Paramedic**

SOP Revised 11/30/2024

Candidate		Date	
Evaluator		Provider Level	
Agency / ID		Attempt #	

Protocols Used**Used within:**

- Pediatric Advanced Airway
- Pediatric Airway Obstruction

Indications**Indicated for:**

- Failure to intubate, failure to ventilate with a BVM
- Other devices or rescue techniques have failed / not available
- Pediatric < 10 years old

Contraindications**Do not perform if:**

- Ability to secure airway with less invasive methods
- Airway trauma that makes cricothyroid membrane access futile – laryngeal fracture, tracheal transection

Equipment**Required:**

- 10–14 G IV catheter
- 10 mL syringe
- 3.0 ETT adapter

Performance Steps

#	Performance Step	Successful	Unsuccessful
1	Continue ALS care as indicated by specific protocol.	☐	☐
2	Place patient in supine position. Hyperextend neck to make anatomy accessible. Consider towel roll under neck.	☐	☐
3	Stabilize larynx/trachea with non-dominant hand using thumb and middle finger. Locate and palpate the cricothyroid membrane between the thyroid and cricoid cartilage.	☐	☐
4	Prepare the area with betadine or similar antiseptic.	☐	☐
5	Attach 10 mL syringe to 10–14 G IV catheter. Insert IV catheter at a 45-degree angle through the cricothyroid membrane into the trachea.	☐	☐
6	Aspirate air through syringe to confirm entry of needle into the trachea.	☐	☐
7	Hold needle/syringe firmly. Slide plastic cannula forward into the trachea until flush against the neck.	☐	☐
8	Remove needle and syringe.	☐	☐
9	Attach 3.0 ETT adapter to syringe hub.	☐	☐
10	Connect BVM to ETT adapter.	☐	☐

#	Performance Step	Successful	Unsuccessful
11	Confirm placement with EtCO2. Secure hub to neck.	☐	☐

Notes / Critical Criteria

- The Gold Standard in confirmation of placement is Capnography. Secondary methods include auscultation, bilateral chest rise and fall, fogging of the tube, and pulse oximetry.

Evaluation Result

Result	☐ PASS / Competent ☐ Needs Remediation	Date	
Comments			
Evaluator Signature			

Cricothyrotomy – SurgicalScope of practice: **Paramedic**

SOP Revised 11/30/2024

Candidate		Date	
Evaluator		Provider Level	
Agency / ID		Attempt #	

Protocols Used**Used within:**

- Adult Drug Assisted Intubation
- Adult Airway Obstruction
- Pediatric Advanced Airway
- Pediatric Airway Obstruction

Indications**Indicated for:**

- Airway cannot be secured by non-surgical methods
- Other devices or rescue techniques have failed / not available

Contraindications**Do not perform if:**

- Pediatric patient < 10 years old
- Ability to secure airway with less invasive methods
- Airway trauma that makes cricothyroid membrane access futile – laryngeal fracture, tracheal transection

Equipment**Required:**

- 10 blade scalpel
- 5.5–6.0 ETT
- Lubricant
- ETT holder
- 10 mL syringe
- Gauze
- OPTIONAL: Bougie, Tracheal hook, Pediatric Magill forceps

Performance Steps

#	Performance Step	Successful	Unsuccessful
1	Continue ALS care as indicated by specific protocol.	☐	☐
2	Place patient in supine position. Extend neck to make anatomy accessible.	☐	☐
3	Stabilize larynx/trachea with non-dominant hand using thumb and middle finger. Locate and palpate the cricothyroid membrane between the thyroid and cricoid cartilage.	☐	☐
4	Prepare the area with betadine or similar antiseptic.	☐	☐
5	Using the dominant hand, make a 0.5–1 inch vertical incision through the skin, exposing the cricothyroid membrane. Do not puncture through the membrane yet.	☐	☐
6	Using the non-dominant hand (pointer finger), re-palpate the cricothyroid membrane.	☐	☐

#	Performance Step	Successful	Unsuccessful
7	Using the dominant hand, make a horizontal incision through the center of the cricothyroid membrane. Extend the incision to each interior edge of the cricoid cartilage.	☐	☐
8	Place tool into incision (pediatric Magill forceps, curved hemostat, bougie, tracheal hook, or non-dominant finger). Once placed, remove scalpel.	☐	☐
9	Confirm tool is properly placed in tracheal lumen – ensuring it is not in a false lumen or through the posterior trachea.	☐	☐
10	Pass ET tube (over bougie if using) and intubate trachea.	☐	☐
11	Remove bougie if using, connect BVM with EtCO2, and verify placement.	☐	☐
12	Inflate balloon and secure with commercial device. Continue to monitor with Capnography throughout.	☐	☐

Notes / Critical Criteria

- Ignore any bleeding until the ET tube has been placed; placement typically has a tamponade effect.
- Take care not to penetrate through the posterior wall of the trachea during the horizontal or vertical incision.
- If using a bougie, insert and aim toward the feet. Verify it is not in a false lumen. Bougie should stop at the carina < 4 inches from the incision.
- The Gold Standard in confirmation of placement is Capnography. Secondary methods include auscultation, bilateral chest rise and fall, fogging of the tube, and pulse oximetry.

Evaluation Result

Result	☐ PASS / Competent ☐ Needs Remediation	Date	
Comments			
Evaluator Signature			

I-GEL AirwayScope of practice: **Per System scope of practice**

SOP p. 81

Candidate		Date	
Evaluator		Provider Level	
Agency / ID		Attempt #	

Indications**Indicated for:**

- Adult or pediatric patient, unresponsive medical or trauma without a gag reflex
- BVM ventilation ineffective

Contraindications**Do not perform if:**

- Intact gag reflex
- Known esophageal disease, caustic substance ingestion

Performance Steps

#	Performance Step	Successful	Unsuccessful
1	Pre-oxygenate patient with BVM with 100% oxygen and appropriate airway adjunct (OPA or NPA).	☐	☐
2	Suction airway as needed.	☐	☐
3	Choose the correct size based on patient weight (see sizing chart).	☐	☐
4	Assemble and check equipment. Apply water-soluble lubricant to back, sides, and front of the cuff (thin layer only on the end to avoid blowing lubricant into the lungs).	☐	☐
5	Place patient in "sniffing" position, or "jaw thrust" if cervical injury suspected. Chin should be pressed down before inserting.	☐	☐
6	Grasp the lubricated i-gel firmly along the bite block. Position so the cuff outlet faces toward the chin of the patient.	☐	☐
7	Introduce the leading soft tip into the mouth toward the hard palate. Glide downward and backward along the hard palate with continuous, gentle push until definitive resistance is felt.	☐	☐
8	Teeth (incisors) should be resting on the integral bite block.	☐	☐
9	Confirm placement by auscultating breath sounds, checking for chest rise, and confirming with EtCO ₂ and SpO ₂ monitoring.	☐	☐
10	Secure the tube with head strap or tape (maxilla to maxilla).	☐	☐
11	If required, pass a lubricated NG or suction catheter down the gastric channel. Apply suction to decompress the stomach.	☐	☐
12	Continue to monitor; sedate per protocol as necessary.	☐	☐

Reference Charts**I-gel Sizing Chart**

I-gel	Patient size	Patient weight (kg)
1.5	Infant	5–12
2	Small pediatric	10–25

I-gel	Patient size	Patient weight (kg)
2.5	Large pediatric	25–35
3	Small adult	30–60
4	Medium adult	50–90
5	Large adult	90+

Evaluation Result

Result	☐ PASS / Competent ☐ Needs Remediation	Date	
Comments			
Evaluator Signature			

Intraosseous Infusion – EZ-IO®Scope of practice: **Paramedic**

SOP p. 85

Candidate		Date	
Evaluator		Provider Level	
Agency / ID		Attempt #	

Indications**Indicated for:**

- Shock, arrest, or impending arrest; unresponsive or conscious critical patient
- 2 unsuccessful IV attempts, or 90-second duration, or no visible sites

Contraindications**Do not perform if:**

- Fracture in same extremity or infection at insertion site
- Previous orthopedic procedures (knee replacement, previous IO within 48 hours)
- Pre-existing medical condition (tumor near site, peripheral vascular disease)
- Inability to locate landmarks (significant edema)

Performance Steps

#	Performance Step	Successful	Unsuccessful
1	Locate and prep insertion site (proximal medial tibia or proximal humerus).	☐	☐
2	Prime EZ-Connect tubing, leaving 9 mL of fluid in syringe.	☐	☐
3	Prepare EZ-IO driver and select appropriate needle set (see chart).	☐	☐
4	Insert EZ-IO needle at 90 degrees through skin until needle stops at bone. The line closest to the hub must remain visible; if not visible, remove needle and place band-aid over site – EZ-IO may not be utilized if the line is not visible.	☐	☐
5	Activate driver by depressing trigger.	☐	☐
6	Once decreased resistance is felt, or needle flange is at skin (whichever first), release trigger.	☐	☐
7	While stabilizing needle hub, remove driver from needle set.	☐	☐
8	Remove stylet from needle by rotating counterclockwise.	☐	☐
9	Connect primed EZ-Connect tubing.	☐	☐
10	Using syringe, aspirate then flush with remaining 9 mL of NS to confirm placement.	☐	☐
11	If conscious patient, administer lidocaine for pain control: – ADULT: LIDOCAINE 1 mg/kg (max 50 mg) over 1–2 minutes. Wait 60 seconds before beginning IVF infusion. May repeat lidocaine x1. – PEDIATRIC: LIDOCAINE 0.5 mg/kg (max 40 mg) over 1–2 minutes. Wait 60 seconds before IVF infusion. May repeat 0.25 mg/kg over 30–60 seconds (max 20 mg).	☐	☐
12	Remove the syringe, attach IV tubing, and begin infusion.	☐	☐
13	Apply pressure bag to IVF to facilitate infusion.	☐	☐
14	Secure tubing to extremity with tape.	☐	☐

#	Performance Step	Successful	Unsuccessful
15	If utilizing proximal humerus site, immobilize the arm to limit movement.	☐	☐
16	Frequently reassess IV bag pressure, amount of fluid infused, site, and patient.	☐	☐

Reference Charts

EZ-IO Needle Selection

Patient	Needle
3–39 kg	15 mm Pink
40 kg+	25 mm Blue
Humeral & Bariatric	45 mm Yellow

Evaluation Result

Result	☐ PASS / Competent ☐ Needs Remediation	Date	
Comments			
Evaluator Signature			

Needle Decompression, Chest

Scope of practice: Paramedic

SOP p. 86

Candidate		Date	
Evaluator		Provider Level	
Agency / ID		Attempt #	

Indications

Indicated for:

- Tension pneumothorax (hypotension with absent breath sounds during ventilation)
- Traumatic arrest with chest trauma

Contraindications

Do not perform if:

- Pneumothorax without hypotension

Performance Steps

#	Performance Step	Successful	Unsuccessful
1	Locate and palpate site at the 2nd intercostal space (above the 3rd rib), mid-clavicular line.	☐	☐
2	Prep site appropriately.	☐	☐
3	Insert 10–14 gauge (2.5–3.25 inch) IV catheter at a 90° angle to the chest wall, until air is released.	☐	☐
4	While holding the needle steady, advance the catheter over the needle until the catheter hub is at the skin.	☐	☐
5	Leave catheter in place and remove the needle.	☐	☐
6	Assess for improvement in clinical status (e.g., increased BP).	☐	☐
7	Frequently reassess patient (especially BP and lung sounds) and catheter patency; may need to repeat procedure if clinical deterioration or catheter occlusion occurs.	☐	☐
8	If a FAILED attempt OR the patient is MARKEDLY OBESE, use the 4th intercostal space, lateral to the inferior mammary fold, mid-axillary line.	☐	☐

Evaluation Result

Result	☐ PASS / Competent ☐ Needs Remediation	Date	
Comments			
Evaluator Signature			

Spinal Motion Restriction (SMR)Scope of practice: **EMR / EMT / Paramedic**

SOP Revised 3/6/2024

Candidate		Date	
Evaluator		Provider Level	
Agency / ID		Attempt #	

Performance Steps

#	Performance Step	Successful	Unsuccessful
1	Collect HPI and PMH and perform an appropriate exam. Maintain C-spine precautions until assessment is complete.	☐	☐
2	Assess for findings requiring FULL IMMOBILIZATION (any one present): – Unconscious – Confused – Non-reliable historian – New-onset neuro deficits	☐	☐
3	If full immobilization is indicated, correctly apply: C-collar, backboard, spider straps, and head blocks.	☐	☐
4	If not, assess for special circumstances (any one present): – Known spinal disease – Previous c-spine injury – Intoxication impairing assessment – GCS < 14 – Language barrier	☐	☐
5	Assess for a dangerous mechanism of injury (any one present): – Fall from elevation – Axial loading to head (dive) – High-speed MVC – Rollover / ejection – Motorized recreation vehicle accident – Vehicle vs. pedestrian/bicycle	☐	☐
6	Assess for significant distracting injuries (any one present): – Multiple fractures – Open wounds	☐	☐
7	If SMR is indicated (special circumstances, dangerous MOI, or distracting injury), correctly apply: C-collar, padded stretcher, and patient supine.	☐	☐
8	If no criteria are met, transport in position of comfort.	☐	☐
9	Use a backboard only as a transfer device to move the patient to the stretcher; if the patient does not meet conditions for full immobilization, remove the backboard as soon as feasible.	☐	☐

Reference Charts**SMR Decision Reference**

Finding category	Required action
Unconscious / confused / non-reliable historian / new neuro deficit	FULL IMMOBILIZATION (C-collar, backboard, spider straps, head blocks)
Special circumstances OR dangerous MOI OR distracting injury	SPINAL MOTION RESTRICTION (C-collar, padded stretcher, supine)
None of the above	Transport in position of comfort

Evaluation Result

Result	☐ PASS / Competent ☐ Needs Remediation	Date	
Comments			
Evaluator Signature			

Synchronized CardioversionScope of practice: **Paramedic**

SOP Revised 4/1/2024

Candidate		Date	
Evaluator		Provider Level	
Agency / ID		Attempt #	

Protocols Used**Used within:**

- Adult Supraventricular Tachycardia
- Pediatric Unstable Tachycardia
- Pediatric Stable Tachycardia
- Adult Rapid Atrial Fibrillation
- Adult Ventricular Tachycardia with a Pulse

Performance Steps

#	Performance Step	Successful	Unsuccessful
1	Continue ALS care as indicated by specific protocol.	☐	☐
2	Place limb leads and combo pads in the anterior-posterior positioning. Anterior (–): V4 positioning. Posterior (+): just under the (L) scapula, between spine and (L) scapula.	☐	☐
3	Turn on Synch. Ensure synch indicators are shown above each QRS complex.	☐	☐
4	Select appropriate joule dosage based on the chart below.	☐	☐
5	Once charged and patient is cleared, press and hold to shock.	☐	☐
6	Document settings in the patient care report.	☐	☐

Reference Charts**Cardioversion Dosing – SVT / Narrow Complex Tachycardia**

Zoll	LifePak	Phillips	Pediatric
70 J	50 J	50 J	Initial: 1 J/kg
120 J	100 J	100 J	2nd: 2 J/kg
150 J	—	150 J	
200 J	—	—	

Cardioversion Dosing – Rapid Atrial Fibrillation / Flutter (Adult)

Zoll	LifePak	Phillips
120 J	100 J	100 J
150 J	200 J	150 J
200 J	300 J	200 J
—	360 J	—

Cardioversion Dosing – Ventricular Tachycardia with a Pulse

Zoll	LifePak	Phillips	Pediatric
120 J	100 J	100 J	Initial: 1 J/kg
150 J	200 J	150 J	2nd: 2 J/kg

Zoll	LifePak	Phillips	Pediatric
200 J	300 J	200 J	
—	360 J	—	

Evaluation Result

Result	☐ PASS / Competent ☐ Needs Remediation	Date	
Comments			
Evaluator Signature			

Tarp Assisted Cooling with Oscillation (TACO Method)Scope of practice: **EMR / EMT / Paramedic**

SOP Revised 6/28/2024

Candidate		Date	
Evaluator		Provider Level	
Agency / ID		Attempt #	

Protocols Used**Used within:**

- Exertional Heat Stroke

Indications**Indicated for:**

- AMS following strenuous athletic activities
- Rectal temperature > 104°F following strenuous athletic activities

Equipment**Required:**

- Large tarp or body bag
- Ice
- Water

Performance Steps

#	Performance Step	Successful	Unsuccessful
1	Continue care as indicated by specific protocol.	☐	☐
2	Remove excess clothing or equipment from the patient.	☐	☐
3	Unfold the tarp/body bag. Place patient in the middle of the tarp/body bag, which acts as a make-shift tub.	☐	☐
4	Pick up each corner of the tarp/body bag to form a sling or "taco" shape around the patient.	☐	☐
5	Slowly pour cool water and ice into the tarp/body bag up to the patient's chest.	☐	☐
6	Gently move the tarp/body bag back and forth to agitate the water and start the cooling process.	☐	☐
7	Monitor the patient's vitals and rectal temperature. Only remove the patient once rectal temperature reaches < 102°F or AMS resolves (if rectal thermometer is available).	☐	☐
8	Once patient is cooled to < 102°F, transport to the closest appropriate comprehensive emergency department.	☐	☐

Evaluation Result

Result	☐ PASS / Competent ☐ Needs Remediation	Date	
Comments			
Evaluator Signature			

Tourniquet Use

Scope of practice: EMR / EMT / Paramedic

SOP p. 88

Candidate		Date	
Evaluator		Provider Level	
Agency / ID		Attempt #	

Indications

Indicated for:

- Severe / life-threatening extremity hemorrhage that continues after direct pressure and/or pressure dressing
- May be used first-line for extremity amputation

Performance Steps

#	Performance Step	Successful	Unsuccessful
1	Place as far distally on the extremity as possible, 2–3 inches proximal to the wound.	☐	☐
2	Place on bare skin if possible.	☐	☐
3	Tighten windlass rod until bleeding stops and pulse is no longer palpable.	☐	☐
4	Monitor for further bleeding; tighten tourniquet only if necessary. If bleeding is not controlled, consider an additional tourniquet applied proximal to the first.	☐	☐
5	Record placement time and notify MEDICAL CONTROL of tourniquet use.	☐	☐
6	Consider pain management.	☐	☐

Notes / Critical Criteria

- Tourniquet removal: if placed prior to EMS arrival and determined to be unnecessary, contact MEDICAL CONTROL to consider removal.
- Do not place tourniquet over a joint.
- Do not cover the tourniquet with a dressing or splint.
- Do not cover a wound, impaled foreign body, or open fracture.
- Lower leg injuries may require thigh placement for adequate compression.

Evaluation Result

Result	☐ PASS / Competent ☐ Needs Remediation	Date	
Comments			
Evaluator Signature			

Transcutaneous Pacing

Scope of practice: **Paramedic**

SOP Revised 4/22/2024

Candidate		Date	
Evaluator		Provider Level	
Agency / ID		Attempt #	

Protocols Used

Used within:

- Adult Bradycardia
- Pediatric Bradycardia
- Calcium Channel Blocker OD
- Beta Blocker OD

Performance Steps

#	Performance Step	Successful	Unsuccessful
1	Continue ALS care as indicated by specific protocol.	☐	☐
2	Place limb leads and combo pads in the anterior-posterior positioning. Anterior (-): V4 positioning. Posterior (+): just under the (L) scapula, between spine and (L) scapula.	☐	☐
3	Ensure pacer is set to DEMAND at a RATE of 80/minute.	☐	☐
4	Turn pacer on.	☐	☐
5	Increase mA until electrical capture is seen on the monitor (electrical capture: 1 pacer spike per wide QRS complex).	☐	☐
6	Verify mechanical capture at the same rate seen on the monitor (mechanical capture: femoral or (R) brachial/radial pulse corresponding to paced beats).	☐	☐
7	Document settings in the patient care report.	☐	☐

Notes / Critical Criteria

- Do not assess carotid or (L) brachial/radial pulses to determine mechanical capture due to interference from muscle contraction.

Evaluation Result

Result	☐ PASS / Competent ☐ Needs Remediation	Date	
Comments			
Evaluator Signature			