COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES SYSTEMS

CLASS EVALUATION SUMMARY

PLEASE TYPE OR PRINT CLEARLY

Class Number

		—							—						

Sponsor Name: _____ **Sponsor Number:** _____

Instructional Quality

Instructional Staff:

_____

_____

Time Appropriately Used: _____

_____

_____

Learning Environment

Classroom/Training Site: _____

_____

_____

Equipment/AV: _____

_____

_____

Miscellaneous Remarks

_____

_____

_____

_____

ROUTING:
- ☐ Sponsor
- ☐ Regional EMS Council