

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

**CLASS EVALUATION SUMMARY**

PLEASE TYPE OR PRINT CLEARLY

Class Number: 

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Sponsor Name: \_\_\_\_\_ Sponsor Number: \_\_\_\_\_

**Instructional Quality**

**Instructional Staff:**

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**Time Appropriately Used:**

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**Learning Environment**

**Classroom / Training Site:**

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**Equipment / AV:**

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**Miscellaneous Remarks**

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ROUTING:  
Sponsor  
Regional EMS Council