

Print Neatly in UPPER CASE Letters – Please Complete ALL Information – Incomplete forms will be denied and returned

EMT Number	Agency Code	Social Security Number XXX — XX —
_____	_____	_____
Last Name		Phone
_____		_____
First Name		MI
_____		_____
Address		

City	State	Zip Code
_____	_____	_____

I have read and agree to follow all requirements for participating in the NYS Continuing Education Recertification Program as found in the current CME Program Manual. Participation is contingent on maintaining current certification as an EMT, AEMT, CC or Paramedic. I understand that as a participant in this program I may be required to complete surveys or questionnaires regarding my participation. The Bureau of Emergency Medical Services or its designee may randomly audit this program and view records pertaining to my participation in continuing education activities. This audit may include written testing and practical skills evaluation. The Bureau or its agent may contact the REMAC, Medical Director(s), receiving hospital personnel, officers of my EMS agency, and others to discuss my participation.

Participant Initials

I hereby affirm that all statements on this recertification form are true and correct, including all copies of cards, certificates and other required verification. It is understood that false statements or documents submitted with the intent to falsely recertify may be grounds for revocation of certification and applicable civil and criminal penalties. **This form must be mailed and postmarked no less than 45 days prior to your current expiration date!**

Applicant's Printed Name	Signature	Date
_____	_____	_____

I affirm that in accordance with the requirements of 10NYCRR Part 800, I have not been convicted of, or currently charged with any misdemeanors or felonies. I understand if I have charges or a conviction it will be reviewed. I also understand such charges or conviction may not be an automatic bar to recertification. **Do not sign if you have been convicted of any misdemeanor or felony charges that have not previously been cleared by BEMS to be certified.**

Applicant's Signature	Date
_____	_____

As the Physician Medical Director for the Participant's Continuing Education Program I hereby affix my signature attesting to proficiency in all skills outlined in this form.

Medical Director's Printed Name	Signature	NYS MD License Number	Date
_____	_____	_____	_____

This applicant is in continuous practice as an EMS provider with this EMS agency as defined in 10NYCRR Part 800.3(w) and is actively participating in our agency's CME-Based Recertification Program. The agency and applicant understand they must abide by the requirements of the program as detailed in the CME-Based Recertification Program Administration Manual.

Sponsoring Agency Contact / Coordinator' Printed Name	Signature	Date
_____	_____	_____

Official Use

Last Name

First Name

EMT-Paramedic Refresher Training – 35 Hours

Topic Area	Required Hours	Hours Earned	Date	Course	Source/ Method
Preparatory	2.0				
Airway	3.0				
Pharmacology, Med. Admin., Emergency Meds.	3.0				
Immunology	1.0				
Toxicology	1.0				
Endocrine	1.0				
Neurology	1.0				
Abdominal, Geni-Renal, GI, Hematology	1.0				
Respiratory	3.0				
Psychiatric	2.0				
Cardiology	3.0				
Shock & Resuscitation	4.0				
Trauma	3.0				
Geriatrics	2.0				
OB, Neonate, Pediatrics	2.0				
Special Needs Pt.	1.0				
EMS Operations	2.0				
TOTALS	35.0				

CIC Signature

CIC Print Name

CIC Number

Last Name _____

First Name _____

Mandatory Topics 5 hours

Topic Area	Required Hours	Hours Earned	Date	Course	Source/ Method
Mental Health of EMT	1.0	_____	_____	_____	_____
Patient Lifting and Moving	1.0	_____	_____	_____	_____
Safe Transport of Ped. Patients	1.0	_____	_____	_____	_____
Emergency Vehicle Driver Training	2.0	_____	_____	_____	_____
TOTALS	5.0	_____	_____	_____	_____

Additional 20 Hours of Continuing Education

Topic Area	Required Hours	Hours Earned	Date	Course	Source/ Method
	N/A	_____	_____	_____	_____
	N/A	_____	_____	_____	_____
	N/A	_____	_____	_____	_____
	N/A	_____	_____	_____	_____
	N/A	_____	_____	_____	_____
	N/A	_____	_____	_____	_____
	N/A	_____	_____	_____	_____
	N/A	_____	_____	_____	_____
	N/A	_____	_____	_____	_____
	N/A	_____	_____	_____	_____
	N/A	_____	_____	_____	_____
	N/A	_____	_____	_____	_____
	N/A	_____	_____	_____	_____
	N/A	_____	_____	_____	_____
Total Hours		_____	_____	_____	_____

CPR, ACLS and PALS *A Copy of Current Card (front and back) MUST Accompany This Application*

Skill Competency Verification PSE Skill Sheets must be used.

Skill	Training Officer's Signature
Patient Assessment (Medical and Trauma)	_____
Airway/Ventilation (Simple Adjuncts, Supplemental Oxygen Delivery, BVM – one and two rescuer)	_____
Cardiac Arrest Management	_____
Hemorrhage Control and Splinting (long bone injury, joint injury, and traction splinting)	_____
IV Therapy/IO Therapy/Medication	_____