NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

EMT – Intermediate Recertification Form
Continuing Education Recertification Program

Print neatly in UPPER CASE letters. Please complete ALL information. Incomplete forms will be denied and returned.

EMT Number

Social Security Number – –

Last Name

First Name MI

Address

City State

ZIP Code –

Agency Code of Your Participating Agency

I affirm that in accordance with the requirements of 10NYCRR Part 800.8(e), I have not been convicted of or am not currently charged with any misdemeanors or felonies. I understand that if I have a conviction it will be individually reviewed and that any such conviction may not be an automatic bar to certification. The Department of Health will determine if the conviction is applicable under the provisions of 10NYCRR Part 800.8(e).

Applicant's Signature

Date / /

EMT-B Refresher Training 24 Hours Total in These Topic Areas

Division	Required Hours	Hours Earned	CIC Signature	CIC Number
Preparatory	1			
Airway	2			
Patient Assessment	3			
Medical/Behavioral (See Subcategories)				
General Pharmacology/Respiratory/Cardiac	4			
Diabetes/Altered Mental/Allergies	2			
Poisoning/Environmental/Behavioral	2			
Trauma	4			
Obstetrics/Gynecology	2			
Infants and Children	2			
Elective	2			
TOTAL HOURS	**24**			

CPR Certification A copy of the card issued must accompany this application if the instructor does not sign.

As the participant's CPR Instructor, I hereby verify that the participant has satisfactorily completed and shows competence in:
Adult, Child and Infant 1 & 2 Rescuer CPR and Obstructed Airway Management.

Printed Name of Instructor

Instructor's Signature

Date / /

EMT-I Refresher Training 10 Hours Total in These Topic Areas

Topic	Required Hours	Hours Earned	CIC Signature	Date
Preparatory	2			
Advanced Airway Management/Ventilation	3			
Patient Assessment	2			
Trauma	3			
TOTAL HOURS	**10**			

Additional 38 Hours of Continuing Education Must include *mandatory* training in Geriatrics and WMD as noted.

Topic	Hours	Date
Geriatric 3 Hours Minimum		
WMD/Terrorism 3 Hours Minimum		

Topic	Hours	Date
TOTAL HOURS		

Skill Competency Verification

Skill	QA/QI	Direct Observation
Patient Assessment (Medical *and* Trauma)		
Airway/Ventilation (Simple Adjuncts, Advanced Adjuncts, Supplemental Oxygen Delivery, Bag Valve-Mask – 1 & 2 Rescuer)		
Cardiac Arrest Management/AED		
Hemorrhage Control & Splinting (Long Bone Injury, Joint Injury and Traction Splinting)		
IV Therapy		
Spinal Immobilization (Seated *and* Supine)		

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

Printed Name of Medical Director

Medical Director's Signature

Date ___ / ___ / ____

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 all false statements or documents submitted with the intent to falsely recertify may be grounds for revocation of certification and applicable civil and criminal penalties. It is also understood that the Bureau of Emergency Medical Services or its designee may conduct an audit of the activities listed herein at any time. **This form must be mailed and postmarked no less than 45 days prior to your current expiration date.**

Participant's Signature

Date ___ / ___ / ____

Sponsoring Agency Contact/Coordinator's Signature

Date ___ / ___ / ____