

Additional 24 Hours of Continuing Education

Topic	Hours	Date	Topic	Hours	Date
Total Hours					

Skill Competency Verification

Skill	QA /QI	Direct Observation	Other
Patient Assessment (Medical and Trauma)			
Airway/Ventilation (Basic Adjuncts, Advanced Adjuncts, Supplemental Oxygen Delivery)			
Cardiac Arrest Management (Therapeutic Modalities, Megacode, Monitor/Defibrillator Knowledge)			
Hemorrhage Control & Splinting			
IV Therapy / Medication Administration			
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 _____ Signature of Medical Director _____ 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 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.

Signature of Participant _____

Signature of Sponsoring Agency Contact / Coordinator _____

Date _____

Date _____