NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services and Trauma Systems

EMT-Paramedic Recertification

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

Enter 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.

Applicant's Signature

Date

CPR Certification	***A Copy of Current Card (front and back) MUST Accompany This Application****
ACLSCertification	***A Copy of Current Card (front and back) MUST Accompany This Application****

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 – one and two rescuer)		
Cardiac Arrest Management (Therapeutic Modalities, Megacode, Monitor/Defibrillator Knowledge)		
Hemorrhage Control and Splinting (long bone injury, joint injury, and traction 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

EMT-Paramedic Refresher Training – 48 Hours

Division	Required Hours	Hours Earned	CIC Initials
Preparatory	6		
Airway	6		
Trauma	10		
Medical (see sub categories)			
Pulmonary and Cardiology	6		
Neurology/Endocrinology/Allergies and Anaphylaxis	3		
Gastroenterology/Renal and Urology/Toxicology/Hematology	3		
Environmental Conditions/Infectious and Communicable Diseases/Behavioral	3		
Gynecology and Obstetrics	3		
Special Considerations (see sub categories)			
Neonatology and Pediatrics	3		
Abuse and Assault	1		
Patients w/Special Challenges and Acute Interventions for Chronic Care Patients	2		
Operations	2		
TOTALS	48		

Additional 24 Hours of Continuing Education

Topic	Hours	Date	Topic	Hours	Date

Total Hours _____

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.

This form must be mailed and postmarked no less than 45 days prior to your current expiration date!

Signature of Participant _____ Date _____

Signature of Sponsoring Agency Contact / Coordinator _____ Date _____