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

## **EMT Recertification**

Continuing Education Recertification Program

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First Name  Address  Email 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, EMT-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 wider 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.  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  Date  Date  Date  Date  This applicant's Signature Date  Date  As the Physician Medical Director or Training Officer for the Participant's Continuing Education Program I hereby affix my signatur attesting to proficiency in all skills outlined in this form.  Medical Director or Training Officer Printed Name  Signature  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 b the requirements of the program as detailed in the CME-Based Recertification Program. The agency an	EMT Number	Agency Code		•	
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Official Use	Sponsoring Agency Contact / Co	ordinator' Printed Name Signatur	re		Date
Official OSC	Official Use				

Last Name First Name

## EMT Refresher Training – 20 Hours

Topic Area	Required Hours	Hours Earned	Date	Course	Source/ Method
Preparatory	1.0				
Airway	2.0				
Pharmacology, Med. Admin., Emergency Meds.	1.0				
Immunology	0.5				
Toxicology	0.5				
Endocrine	0.5				
Neurology	0.5				
Abdominal, Geni-Renal, GI, Hematology	1.0				
Respiratory	1.0				
Psychiatric	1.0				
Cardiology	2.0				
Shock & Resuscitation	2.0				
Trauma	2.0				
Geriatrics	1.5				
OB, Neonate, Pediatrics	1.5				
Special Needs Pt.	1.0				
EMS Operations	1.0				
TOTALS	20.0				

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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	g Education				
Topic Area	Required Hours	Hours Earned	Date	Course	Source/ Method
	N/A	Luilled	Dute	Course	Pictilou
	N/A				
Total Hours					
CPR *A Copy of Current Ca	rd (front and b	ack) MUST Ac	company This	Application*	
	ion PSE Skill S				
Skill					Training Officer's Signature
Patient Assessment (Medical and Tr	rauma)				
Airway/Ventilation (Simple Adjunc	ts, Supplement	tal Oxygen De	livery, BVM –	one and two rescuer)	
Cardiac Arrest Management includ	ing AED				
Hemorrhage Control and Splinting	(long bone inj	ury, joint injur	y, and traction	n splinting)	