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

EMT-Critical Care 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

EMT-Critical Care Refresher Training - 36 Hours

Division	Required Hours	Hours Earned	CIC Signature	CIC Number
Preparatory	5			
Airway	5			
Trauma	8			
Medical/Behavioral (see sub categories)				
Respiratory and Cardiac Emergencies	5			
Allergic Reactions and Poisoning	2			
Neurological & Abdominal Emergencies	2			
Environmental/Behavioral/Gynecological	3			
Special Considerations (see sub categories)				
Obstetric Emergencies	2			
Neonatology	1			
Pediatrics	2			
Operations	1			
TOTALS	36			

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

Additional 36 Hours of Continuing Education

Topic	Hours	Date	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 – one and two rescuer)		
Cardiac Arrest Management (Therapeutic Modalities, Megacode, Monitor/Defibrillator Knowledge)		
Hemorrhage Control & 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

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