NEW YORK STATE DEPARTMENT OF HEALTHBureau of Emergency Medical Services

AEMT RECERTIFICATION FORM

Continuing Education Recertification Program

Print	Neat	ly in	UPPE	ER C	ASE L	_etter	s - PI	ease	Com	plete	ALL	nforr	natio	n – In	com	plete	form	s will	be d	enied	and	retur	ned	
EMT Number								Social Security Number																
											-			-										
Last	Nam	е				1											1			_				
First	First Name													MI										
Addr	ess																			•	<u> </u>			
City												•												
Zip Code Enter Agency Code of Your Participating Agency																								
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	I		l		I.	ı		ı	ı	_		I		ı	ı	_								_
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.																								
Applica	ant's Sig	nature										_			Date							_		

EMT Refresher Training - 26 Hours

DIVISION	Required Hours	Hours Earned	CIC Signature	CIC Number
Preparatory	1			
Airway	2			
Patient Assessment	3			
Pharmacology/Med Admin/Emergency Meds	1			
Immunology/Toxicology	1			
Endocrine/Neurology	1			
Abdominal/Geni-Renal/GI/Hematology	3			
Respiratory	1			
Psychiatric	1			
Cardiology	1			
Shock and Resuscitation	1			
Trauma	4			
Geriatrics	2			
OB/Neonate/Pediatrics	2			
Special Needs Patients	1			
EMS Operations	1			
TOTALS	26			•

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CPR Certification *A Copy of	Current C	Card (fro	nt and back) MUST	Accompany ⁻	This App	olicatio	n*
AEMT Refresher Training - 14 Hours To	otal in The	ese Topi	c Areas				
Торіє	Hou Earn		Date				
Preparatory							
Pharmacology							
Advanced Airway Management / Ventila							
Medical	4						
Patient Assessment	2						
Trauma	3						
Additional 32 Hours of Continuing Educ	ation						
Торіс		Hours	s Date				
				Total H	lours		
Skill Competency Verification							
							Diment
	Skill				QA/0	રા or	Direct oservation
Patient Assessment (Medical and Traum							
Airway/Ventilation (Simple Adjuncts, Adv Valve-Mask – one an							
Cardiac Arrest Management / AED							
Hemorrhage Control & Splinting (long b	one injury	, joint inju	ury, and traction splin	ting)			
IV Therapy/Medication Administration							
Spinal Immobilization (Seated and Supir	ne)						
As the Physician Medical Director for the Participant's outlined above.	s Continuing	Education	Program I hereby affix my	signature attesti	ng to profic	ciency in a	all skills
Printed Name of Medical Director Signature Sig	gnature of Med	ical Director		Date			

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Date

Signature of Sponsoring Agency Contact / Coordinator

Signature of Participant

Date