NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

AGENCY REGISTRATION FORM
Continuing Education Recertification Program

Print Neatly in UPPER CASE Letters - Complete ALL Information - Incomplete forms will be returned

Agency Code _____ Agency Name _____

Agency Address _____

City _____ State NY Zipcode _____ County _____

Business Phone _____ Fax _____

E-Mail Address _____

Agency Contact / Program Coordinator

First Name _____ MI _____ Last Name _____

Address _____

City _____ State NY Zipcode _____ Phone _____

As a participating agency in the Continuing Education Recertification Program, This agency will ensure the following:

- An Agency File listing all participants in the program and their progress will be kept on site and up to date within 30 days
- An Individual File for each participant containing record of CME to include sign in sheets, quizzes, practical evaluation records and any items needed to verify completion of CME recorded. This file will be kept on site or by a third party contracted by the agency. If a contracted third party maintains these files, a copy of the contract and the physical location of the files must accompany this application.
- The Bureau of Emergency Medical Services or its designee may inspect all files pertaining to the program upon reasonable request
- Guidelines for the Continuing Education Recertification Program published by the New York State Department of Health Bureau of Emergency Medical Services are met.
- Ensure that participant recertification requests and all necessary documentation is forwarded to the Bureau of Emergency Medical Services no less than 45 days before the participant's current certification expires.

_____ _____
Printed Name of Agency Agent Signature of Agency Agent

_____
Date

Medical Director

First Name _____ MI _____ Last Name _____

Address _____

City _____ State NY Zipcode _____ Phone _____

As Medical Director for this Agency's Continuing Education Program I accept responsibility for:

- Medical Oversight of content for in-house CME sessions (Those not conducted by a NYS Instructor as part of Core Material review)
- Completion of core material review by all participants
- Verification of skills proficiency for all participants

_____ _____
Printed Name of Medical Director Signature of Medical Director

_____
Date