

**NEW YORK STATE DEPARTMENT OF HEALTH**  
Bureau of Emergency Medical Services

**PARTICIPANT REGISTRATION FORM**  
Continuing Education Recertification Program

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

First Name

Last Name

MI

Address

City

State

Zipcode

County (First 4 letters)

Gender (M/F)

Social Security Number

Date of Birth

Phone Number (With Area Code) EMT / AEMT Number

EMT-B

AEMT-I

AEMT-CC

EMT-P

Certification Expiration Date

Agency Code (for participating agency)

CIC

CLI

E-Mail address

**Personal Affirmation - DO NOT sign if you have any criminal convictions**

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 \_\_\_\_\_

**Read Carefully Before Signing**

I have read and agree to the following requirements for participating in the Continuing Education Recertification Program:

Participation is contingent on maintaining current New York State certification as an EMT-B, AEMT-I, AEMT-CC or EMT-P. I will submit a Continuing Education Recertification Form (DOH-XXXX) to the Bureau of Emergency Medical Services no later than 45 days prior to the expiration of my certification. (The Bureau is not responsible for lost or missing documents while in transit to the Bureau).

Participation is strictly voluntary. If I decide, at any time, not to complete the Continuing Education Recertification Program, in order to recertify, I MUST enroll in and complete a New York State EMT/AEMT refresher course, and pass state administered practical and written certifying examinations.

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 view records pertaining to my participation in continuing education activities. This audit may also include written testing and practical skills evaluation. The Bureau or its agent may also contact the REMAC, Medical Director(s), receiving hospital personnel, officers of my EMS agency, and others to discuss my participation. I also understand that if I am a CIC/CLI I must take a written certification examination at the level I am certified to teach and score at least 85% to renew my instructor certification.

Participant Signature \_\_\_\_\_

Date \_\_\_\_\_