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

EMT Recertification

Continuing Education Recertification Program

Print Neatly in UPPER CASE Letters – Please Complete ALL Information – Incomplete forms will be denied and returned

EMT Number _____

Agency Code _____

Social Security Number XXX — XX — _____

Last Name _____

Phone _____

First Name _____

MI _____

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 view 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.

Participant Initials _____

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 _____

I affirm that in accordance with the requirements of 10NYCRR Part 800, I have not been convicted of, or currently charged with any misdemeanors or felonies. I understand if I have charges or a conviction it will be reviewed. I also understand such charges or conviction may not be an automatic bar to recertification. **Do not sign if you have been convicted of any misdemeanor or felony charges that have not previously been cleared by BEMS to be certified.**

Applicant's Signature _____ Date _____

As the Physician Medical Director or Training Officer for the Participant's Continuing Education Program I hereby affix my signature attesting to proficiency in all skills outlined in this form.

Medical Director or Training Officer Printed Name _____ Signature _____ NYS MD License Number _____ Date _____

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 by the requirements of the program as detailed in the CME-Based Recertification Program Administration Manual.

Sponsoring Agency Contact / Coordinator' Printed Name _____ Signature _____ Date _____

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**				

CIC Signature _____

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 Education

Topic Area	Required Hours	Hours Earned	Date	Course	Source/ Method
	N/A				
	N/A				
	N/A				
	N/A				
	N/A				
	N/A				
	N/A				
	N/A				
	N/A				
	N/A				
	N/A				
	N/A				
	N/A				
	N/A				
Total Hours					

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

Skill Competency Verification PSE Skill Sheets must be used.

Skill	Training Officer's Signature
Patient Assessment (Medical and Trauma)	
Airway/Ventilation (Simple Adjuncts, Supplemental Oxygen Delivery, BVM – one and two rescuer)	
Cardiac Arrest Management including AED	
Hemorrhage Control and Splinting (long bone injury, joint injury, and traction splinting)	