NEW YORK STATE DEPARTMENT OF HEALTH **EMT RECERTIFICATION FORM**

Bureau of Emergency Medical Services **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 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**			

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

Additional 46 Hours of Continuing Education

Date	Topic	Hours	Date	Topic	Hours
	TOTAL HOURS			TOTAL HOURS	

Skill Competency Verification

SKILL	QA/QI	Direct Observation
Patient Assessment (Medical **and** Trauma)		
Airway / Ventilation (Simple Adjuncts, Supplemental Oxygen Delivery, Bag Valve-Mask one and two rescuer)		
Hemorrhage Control and Splinting (long bone injury, joint injury, and traction splinting)		
Spinal Immobilization (Seated **and** Supine)		
Cardiac Arrest / Automatic External Defibrillator (AED)		

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 above.

Printed Name of Medical Director / Training Officer _____ Signature of Medical Director / Training Officer _____ 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 _____ Signature of Sponsoring Agency Contact / Coordinator _____

Date _____ Date _____