W e s t c h e s t e r R E M A C

CME /CA ATTENDANCE SHEET

Date _____/_____/_____

☐ **Call Audit** ☐ **CME** **Topic/Title** _____

Time Start _____ Time End _____ Total Time _____

Location _____

Sponsor Hospital _____ Hospital Code _____

	Print Name	NYS EMT #	EMT			Primary Agency	Sign In	Sign Out
			B	A	P			
1								
2								
3								
4								
5								
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15								

I certify that the above listed personnel attended and completed the program identified above.

Physician / Instructor ***(Print Name)*** _____

Physician / Instructor ***(Sign Name)*** _____

NOTE: ***FAX*** or ***EMAIL*** this form to the Regional EMS Office on the first business day following the program.

Page _____ of _____

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