Print Name _____ **EMT #** _____

Agency Name _____ **Agency Code** _____

New York State Department of Health
Bureau of Emergency Medical Services

Pilot Program EMT-Basic Certification Renewal Cover Sheet

Return Completed Application to:

Pilot Recert Program
Bureau of EMS
875 Central Avenue
Albany, New York 12206-1388

DOH Review:

_____ Meets NYS-EMS guidelines for re-registration
_____ Application did not meet the following criteria:

_____
_____
_____
_____

DOH Review by:_____ Date:_____

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

EMT-BASIC RECERTIFICATION FORM

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-B Refresher Training - 24 Hours

DIVISION	Required Hours	Hours Earned	CIC Signature	CIC Number
Preparatory	1			
Airway	2			
Patient Assessment	3			
Medical/Behavioral (see sub categories)				
Gen. Pharmacology/Respiratory/Cardiac	4			
Diabetes/Altered Mental/Allergies	2			
Poisoning/Environmental/Behavioral	2			
Trauma	4			
Obstetrics/Gynecology	2			
Infants and Children	2			
Elective	2			
TOTALS	24			

CPR Certification

As the participant's CPR Instructor I hereby verify that the participant has satisfactorily completed and shows competence in:
Adult, Child and Infant 1& 2 rescuer CPR and Obstructed Airway management

Printed Name of Instructor _____ Signature of Instructor _____ Date _____

* **A COPY OF THE CARD ISSUED MUST ACCOMPANY THIS APPLICATION IF THE INSTRUCTOR DOES NOT SIGN** *

Additional 48 Hours of Continuing Education – Must include mandatory training in Geriatrics and WMD as noted!

Date	Topic	Hours	Date	Topic	Hours
	Geriatrics – 3 hours minimum				
	WMD/Terrorism – 3 hours minimum				
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 _____