

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

EMT Number

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Social Security Number

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Last Name

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First Name

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MI

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Address

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City

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State

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Zip Code

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Enter Agency Code of Your Participating Agency

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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

CPR Certification

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

ACLS Certification

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

Skill Competency Verification

Skill	QA/QI	Direct Observation
Patient Assessment (Medical and Trauma)		
Airway/Ventilation (Simple Adjuncts, Advanced Adjuncts, Supplemental Oxygen Delivery, Bag Valve-Mask – one and two rescuer)		
Cardiac Arrest Management (Therapeutic Modalities, Megacode, Monitor/Defibrillator Knowledge)		
Hemorrhage Control and Splinting (long bone injury, joint injury, and traction splinting)		
IV Therapy / Medication Administration		
Spinal Immobilization (Seated and Supine)		

As the Physician Medical Director 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

Signature of Medical Director

Date

