

Pilot Refresher Core Content 2020

CentreLearn/Target Solutions

Program Registration

EMS providers must be affiliated with a NYS EMS CME Agency (with valid Agency Code) in Chemung County, Schuyler County or Steuben County to participate in the online recertification program. Participants must be affiliated with an agency approved for 100% online CME.

Name: _____

E-mail: _____ Phone number: _____

Street Address: _____

City/ State/Zip: _____

State of Certification: _____ State Certification Level: CFR EMT-B EMT-P

State Certification Number: _____ Expiration date: _____

National Registry Number: _____ Expiration date: _____

Agency Affiliation: _____

Pilot Refresher Core Agreement

It is understood that by enrolling in the Online Refresher program offered by Arnot Ogden Medical Center that I am responsible for the \$500 program fee for Paramedic level/ \$300 program fee for EMT level/ \$100 program fee for CFR level if I do not complete the core content in full by December 31, 2020.

Signature: _____ date: _____

Office Use Only

date account activated _____

username _____

password _____

___DOH-65

___DOH-3312

___DOH-4226

___DOH-4231 or DOH-5065 or DOH-5295

1. Fill out this form legibly and accurately. Failure to do so can cause delay in your being allowed to test or inaccurate information on your certificate.
2. **COURSE NUMBER:** Fill in the course number. It is provided to the Instructor/Coordinator on the course approval slip.
3. Check **ORIGINAL CERTIFICATION** Box if:
 - A. This is the first time you have enrolled in an Emergency Medical Services certification course or,
 - B. You are applying for an advanced EMT certification in a category in which you are not currently certified.
4. Check **RECERTIFICATION COURSE** box if you are applying for recertification, basic or advanced.
5. **EMS IDENTIFICATION NUMBER:** Enter the six (6) numbers of your EMS identification number. If your number is less than six digits, add zeros in front to complete the number of six digits (Example: EMS No. 94 would be 000094). Only enter your New York State EMS number.
6. **NAME:** Enter your last name. If you use a notation after your name (such as Jr.) enter it after your last name. In the next set of boxes, enter your first name in full, leave a space, and enter your middle initial. If you do not have room to enter your name in full, please abbreviate.
7. If your EMS certificate shows an incorrect name or you have changed your name since it was issued, check the box and write in the name that is on your current certificate.
8. **ADDRESS:** Write your mailing address. The first line is for your number and street, or post office box. Leave a space between words for box numbers. The second line is the city, state and the third line is for zip code and county where you will be receiving your mail.
9. **COUNTY:** Enter the county in which you live. **NOTE:** Manhattan is New York (NEWY) - Staten Island is Richmond (RICH) - Brooklyn is Kings (KING) - St. Lawrence is STLA - Out of State is OUTS
10. **DATE OF BIRTH:** Enter your date of birth putting two digits each in the month, day and year boxes. Always use a "0" to complete 2 digits (i.e. January is "01")
11. **SOCIAL SECURITY:** Please fill in the last 4 digits of your social security number. This will be kept confidential by the New York State Department of Health and the Bureau of Emergency Medical Services.
12. **SEX:** M for male, F for female.
13. If you are part of the teaching faculty for this course, check Yes.
14. **AGENCY CODE:** Fill in the Department of Health numerical code assigned to the agency with which you provide prehospital care.
15. **PRACTICAL SKILLS EXAM DATE:** Fill in the date(s) of your Practical Skills Exam. This date will be provided by the Instructor/Coordinator.
16. **EXAMINATION DATE:** Fill in the date that you will be taking the NYS certifying exam. This date will be provided by the Instructor/Coordinator.
17. Read the statement and sign the application (if able) as you normally sign your name, and write in today's date. You are responsible for the statement's truth and accuracy.

Personal Affirmation — DO NOT SIGN if you have any criminal convictions

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 10 NYCRR Part 800.

Applicant's Signature

Date

Read Carefully Before Signing:

I have read and agree to the following requirements for participating in the Continuing Education Recertification Program:

Participation is contingent on maintaining current New York State certification as an EMT-B, AEMT-I, AEMT-CC or EMT-P. I will submit my Continuing Education Recertification Form to the Bureau of Emergency Medical Services no later than 45 days prior to the expiration of my certification.

(The Bureau is not responsible for lost or missing documents while in transit to the Bureau. We strongly suggest that you make a copy of all documents and request a returned receipt for original documentation mailed.)

Participation is strictly voluntary. If I decide, at any time, not to complete the Continuing Education Recertification Program, in order to recertify, I MUST enroll in and complete a New York State EMT/AEMT refresher course, and pass NYS state administered practical and written certifying examinations.

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 also include written testing and practical skills evaluation. The Bureau or its agent may also contact the REMAC, Medical Director(s), receiving hospital personnel, officers of my EMS agency, and others to discuss my participation. I also understand that if I am a CIC/CLI I must take a written certification examination at the level I am certified to teach and score at least 85% to renew my instructor certification.

Participant's Signature

Date

This applicant is currently an active participating EMS Provider 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.

Agency CME Coordinator/Training Officer Signature

Date

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

CFR 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 a CFR. 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 – 15 Hours

Topic Area	Required Hours	Hours Earned	Date	Course	Source/ Method
Preparatory	1.0				
Airway	1.0				
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	1.0				
Shock & Resuscitation	1.0				
Trauma	1.0				
Geriatrics	0.5				
OB, Neonate, Pediatrics	1.0				
Special Needs Pt.	0.5				
EMS Operations	2.0				
TOTALS	15.0				

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 EMS Provider	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 5 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	_____	_____	_____	_____
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)	_____