2010 REMO PAPER TURNAROUND DOCUMENT

DUE TO PRIMARY AGENCY BY DECEMBER 31, 2010

DOCUMENT DUE AT REMO BY JANUARY 31, 2011 - SUBMITTED BY AGENCY ALS COORDINATOR

Last name:	First name:	
EMT#	REMO#	Level of certification:
Mailing address:	City:	Zip:
Email address:	Phone #	
PRIMARY AGENCY:	Cell phone #	
SECONDARY AGENCY:		

SECTION 1 - ALS - 12 HOURS FOR EMT-P & CCT (6 HOURS FOR EMT-I)

Date	Presentation	REMO CME#	Location	CEU total

TOTAL =

SECTION 2 - CREDENTIAL REQUIREMENTS

NYS AEMT	Exp. Date _____/_____/_____	ACLS	Exp. Date _____/_____/_____
CPR	Exp. Date _____/_____/_____	PALS,PEPP,PPCC	Exp. Date _____/_____/_____

SECTION 3 - 12 HOURS ADDITIONAL REQUIRED FOR ALL ALS PROVIDERS

Date	Presentation	REMO CME#	Location	CEU total

TOTAL =

Section IV: Skills Competency - Field (F) verification including sig #, or Lab (L) verification

Required	SKILL	Date/Sig		Date/Sig		Date/Sig		Date/Sig		Required for:
4	Adult ET									ALL providers
2	PEDS ET									MEDIC only
2	Airway adjunct									ALL providers
4	IV									EMT-I only
2	I/O									CCT/P

Additional skill requirement - select and circle one of the following: Date: ______________________

Needle Decompression/ CPAP Operations/ Transport Vent Operations/ 12-lead Operations

Section V: Verification Statements

My signature below verifies that all the information contained within this document is true and correct. I understand that all verification material may be audited by REMO, and that any falsification will be grounds for revocation of my on-line privileges.

AEMT signature: ____

I do hereby affix my signature attesting to the validity of the continuing education documented herein, and documented competency in the skills required to remain on-line within the REMO region. This AEMT is an active provider in good standing with our agency.

ALS Coordinator signature:____

I recommend that this ALS provider remain on-line in the REMO region.

Medical Director signature:____