Pilot Refresher Core Content 2023
Target Solutions

ArnotHealth
Arnot Ogden Medical Center

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: ☐ EMR ☐ 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, 2023.

Signature: _____ date: _____

Office Use Only

date account activated _____

username _____

password _____

___DOH-65 ___DOH-3312 ___DOH-4226 ___DOH-4231 or DOH-5065 or DOH-5295

rev. 1/2023

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

Application for Emergency Medical Services Certification

Please print legibly in capital letters or type. Put letter or number in each box.

Course Number | | | | | | | **(Please retain this number for future reference)**

Check if this application is for: ☐ **Original Certification** ☐ **Recertification** **(If you are recertifying you must include your NYS EMS I.D. Number)**

EMS Identification Number (If you have one)
Only write your NYS EMS number in this space

Last Name

First Name and M.I.

Check this box if your name as stated above has changed or is spelled differently than on your current EMS card ☐
Enter on the line below, your name as it appears on your current EMS card.

(Please Print Clearly or Type)

Address
Number and Street **(Skip one space between number and street)**

City **State**

Zip Code **County** **Date of Birth**

Month **Day** **Year**

Social Security **Sex** **On Teaching Faculty**

X X X X X | | | | |

(Enter M or F) **YES** **NO**

If you belong to an EMS agency, please indicate the agency code in the box(es) below.

Primary EMS Agency **Secondary EMS Agency**

Day Telephone **Practical Skills Exam Date** **NYS Written Exam Date**

Month **Day** **Year** **Month** **Day** **Year**

Personal Affirmation **Read Carefully Before Signing**

I affirm that in accordance with the requirements of 10 NYCRR Part 800, I have NOT been convicted of 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 Part 800.

Do not sign this if you have any convictions

I hereby certify that all of the information contained in this application is true and correct and that the signature below is mine as applicant. I further understand that offering or providing false information on this document may constitute a crime under the penal law and may subject any certification to revocation or other Department action.

(Applicant Signature) **(Date)**

CLICK TO PRINT

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 you 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 codeand 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.**

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

Verification of Membership in a NYS EMS Agency

Please print legibly in capital letters or type. Put one letter or number in each box.
This form must be completed and returned to the Course Sponsor prior to the completion of the course.

Course Number | | | | | | | **(Please retain this number for future reference)**

Check if this application is for: ☐ **Original Certification** ☐ **Recertification** **(If you are recertifying you must include your NYS EMS I.D. Number)**

EMS Identification Number (If you have one)
Only write your NYS EMS number in this space

Applicant's Last Name

Applicant's First Name and M.I

If you belong to an EMS agency, please indicate the agency code in the box(es) below.

Primary EMS Agency **Secondary EMS Agency**

Primary Agency Name

Primary Agency Captain, Chief, or other agency official signing the affirmation on this form

Last Name

First Name and M.I.

NYS EMS Identification Number (If you have one)

Official's Agency Title

Personal Affirmation **Read Carefully Before Signing**

I, as an official representative of the primary NYS EMS agency listed on this form, affirm that the applicant named on this form is a member of the primary NYS EMS service. I further understand that offering or providing false information on this document may constitute a crime under the penal law and may subject any certification to revocation or other Department action.

I, as the applicant, hereby certify that all of the information contained in this application is true and correct and that the signature below is mine as applicant. I further understand that offering or providing false information on this document may constitute a crime under the penal law and may subject any certification to revocation or other Department action.

(Agency Official's Signature) **(Date)**

(Applicant's Signature) **(Date)**

Participant Registrant Form
Continuing Education Recertification Program

Print neatly in UPPER CASE letters. Complete ALL information. Incomplete forms will be denied and returned.

First Name | MI

Last Name

Address

City | State

ZIP Code | County | Sex

FIRST FOUR LETTERS | M/F

Social Security Number

Participating Agency
DOH Agency Code | EMT/AEMT Number | EMT-B | AEMT-I | AEMT-CC | EMT-P

CHECK APPROPRIATE CERTIFICATION LEVEL

EMT/AEMT Expiration Date

Check the circle that indicates the best number to be reached in the event of a problem with your CME application.

Home Phone

AREA CODE

Work Phone

AREA CODE

Cell Phone

AREA CODE

CIC | CLI

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 _____

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services and Trauma Systems

CFR Recertification

Continuing Education Recertification Program

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)	