

EMT-PARAMEDIC RECERTIFICATION REPORT

Current healthcare provider CPR certification (must meet American Heart Association standards or equivalent) is a requirement and a prerequisite for recertification. The CPR course may not be applied toward CME hours and the CPR card shall not expire the same month your Clark County certificate expires. All other required provider cards must be current at time of recertification (attach copies). Recertification for EMT-Paramedic status requires completion of 60 hours of CME's biennially as outlined in the District Procedure for EMT-Paramedic Recertification, along with successful completion of EMT-Basic, Intermediate and Paramedic skills as defined on the Health District's Skills Proficiency Record. A certificate of completion must be submitted for all approved refresher courses, along with the course coordinator's signature on the back of this form. All additional CMEs must be notated below, along with supporting documentation. A minimum of 12 of the 60 hours must be done in a classroom setting.

SECTION I: REQUIRED CONTINUING MEDICAL EDUCATION (CME)

| CATEGORIES | REQUIRED HOURS | HOURS COMPLETED | DATE COMPLETED |
|---|-----------------|---|---|
| OPERATIONAL _____ | 2 Hours | _____ | _____ |
| TRAUMA _____ _____ _____ _____ _____ | 6 Hours | _____ _____ _____ _____ _____ | _____ _____ _____ _____ _____ |
| MEDICAL EMERGENCIES _____ _____ _____ _____ _____ | 8 Hours | _____ _____ _____ _____ _____ | _____ _____ _____ _____ _____ |
| AIRWAY/BREATHING/CARDIOLOGY _____ _____ _____ _____ _____ _____ _____ _____ _____ | 16 Hours | _____ _____ _____ _____ _____ _____ _____ _____ _____ | _____ _____ _____ _____ _____ _____ _____ _____ _____ |

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| | REQUIRED HOURS | HOURS COMPLETED | DATE COMPLETED |
|-----------------|-----------------------|------------------------|-----------------------|
| OB/PEDS | 16 Hours | _____ | _____ |
| _____ | | _____ | _____ |
| _____ | | _____ | _____ |
| _____ | | _____ | _____ |
| _____ | | _____ | _____ |
| _____ | | _____ | _____ |
| _____ | | _____ | _____ |
| _____ | | _____ | _____ |
| _____ | | _____ | _____ |
| _____ | | _____ | _____ |
| ELECTIVE | 12 Hours | _____ | _____ |
| _____ | | _____ | _____ |
| _____ | | _____ | _____ |
| _____ | | _____ | _____ |
| _____ | | _____ | _____ |
| _____ | | _____ | _____ |
| _____ | | _____ | _____ |
| _____ | | _____ | _____ |

SECTION II: CERTIFICATION

I, _____, attest that I have completed the above CME hours in the
 (Print Applicant’s Name)
 categories listed and all statements on the Recertification Report are true and correct. I understand false statements or submission of false documents may be sufficient cause for forfeiture of the right to recertification by Southern Nevada Health District.

 (Applicant’s Signature)

I, _____, attest that documentation of the above listed CME hours
 (Print Name)
 is on file at the training center and all statements on the Recertification Report are true and correct. I understand false statements or submission of false documents may be sufficient cause for forfeiture of the right to recertification by Southern Nevada Health District.

 (Education Coordinator’s Signature)