NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

EMT-BASIC RECERTIFICATION FORM
Continuing Education Recertification Program

EMT Number | Social Security Number

Last Name | First Name | MI

Address

City | State | Zipcode | EMS Agency Code

NY

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.

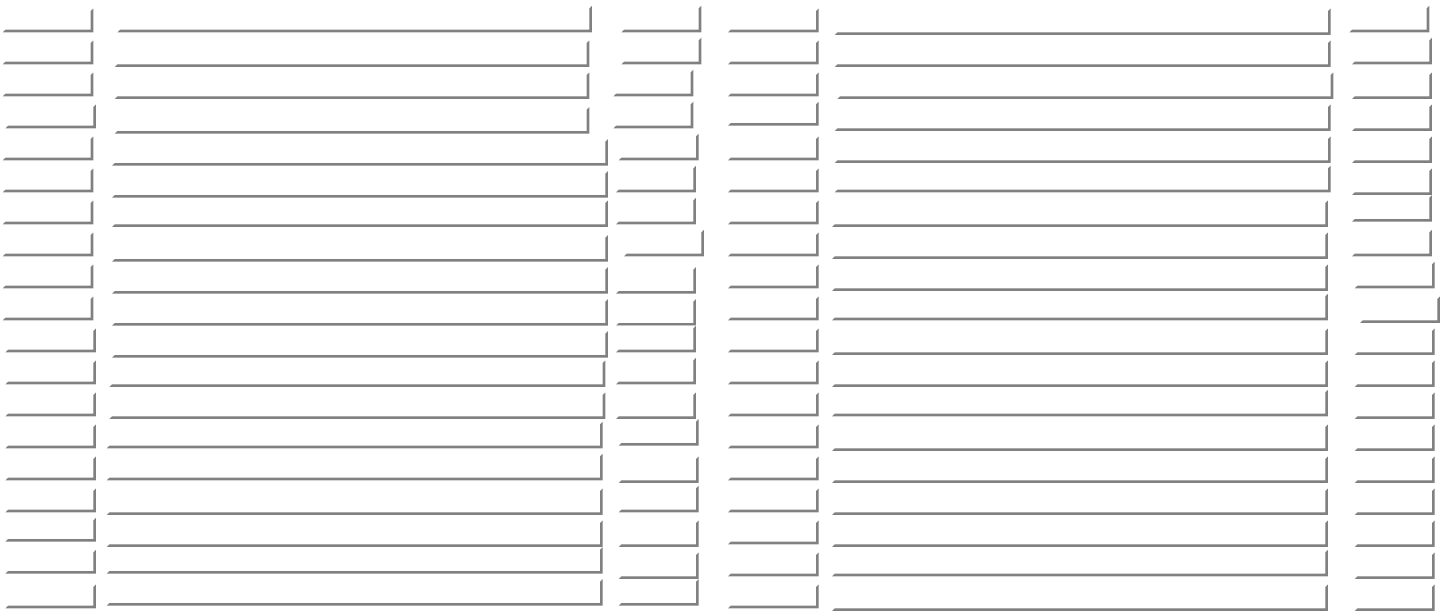
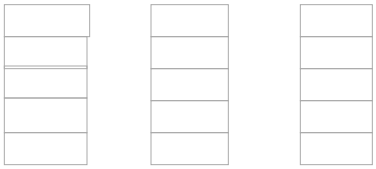
Applicant's Signature _____ Date _____

EMT-B Refresher Training - 24 Hours

DIVISION	Required Hours	Hours Earned	Date Completed	CIC Signature	CIC Number
Preparatory	1				
Airway	2				
Pt. Assessment	3				
Medical/Behavioral	4				
Trauma	4				
OB, Infants, Children	2				
Elective	8				
TOTALS	**24**				

CPR Certification

As the participant's CPR Instructor I hereby verify that the participant has satisfactorily completed and shows competence in:
Adult, Child and Infant 1& 2 rescuer CPR an Obstructed Airway management

Printed Name of Instructor _____ Signature of Instructor _____ Date _____

*** A COPY OF THE CARD ISSUED MUST ACCOMPANY THIS APPLICATION***