NEW YORK STATE DEPARTMENT OF HEALTH Bureau of Emergency Medical Services

Application for AEMT Rapid Recertification

Please pl	rint legibly in capital letters or type	e. Put only one letter or	number in each box.
Course Number	(Please retain	this number for future re	eference.)
Check if this application is	for: Original Certification	X Recertification	This form should only be used for AEMT Rapid Recertification, and must be attached to a Course Memorandum and submitted by an approved course sponsor.
EMS Identification Number Write your NYS EMS number			Both sides of this form must be completed and signed.
Last Name			
First Name and M.I.			
-	e as stated above has changed or vided below, enter your name as i		-
Address Number and Street (Skip	one space between number and stre	et)	
City			State
Zip Code Social Security # If you belong to an EMS ag Primary EMS Agency	County ency, please indicate the code in Secondary EMS Agency	Sex [(Enter M or F)	Oate of Birth MONTH DAY YEAR On Teaching Yes Faculty
Day Telephone #	Practic	cal Skills Exam Date	NYS Written Exam Date
understand that if I have a corcertification. The Department of I hereby certify that all of the inapplicant. I further understand	nviction it will be individually reviewed of Health will determine if the convicti Do not sign this if you Information contained in this application	and that any such conviction is applicable under the und	e provisions of Part 800.
Signature	of Applicant	_	Date

THIS SIDE OF FORM SHOULD ONLY BE USED FOR AEMT RAPID RECERTIFICATION

I,		, serving in the capacity of Service Medical
Name of Service Medical Director		
Director for _		due affirm that
	Name of	ALS Service
		_ is deemed competent and qualified for admission to the
Name	of AEMT Recertification Applicant	
State practica	al skills examination and subsequer	nt State written certification examination in accordance
with the Stat	te EMS Code (10 NYCRR 800) and	the policies and procedures of the Bureau of Emergency
Medical Sen	vices. I affirm that the applicant mee	ets at minimum all the following criteria:

- * Actively practicing as a New York State certified AEMT within a regionally approved ALS system.
- * Clinically competent and qualified to practice as an AEMT.
- * Remains proficient in all of the cognitive and performance objectives of the New York State approved AEMT curriculum.
- * In the judgement of the Service Medical Director the candidate is of sound character and judgement.
- * Successfully completed the national cognitive and skills objectives in Basic Cardiac Life Support (BCLS), Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care as outlined in the *Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care: Recommendations of the [most current] National Conference.*
- * Other requirements as set forth by the Service Medical Director.

The determination of whether a candidate meets the above criteria is made solely by the Service Medical Director and should be based on, but not limited to, direct clinical observation, evaluation of performance through quality improvement/quality assurance activities, in-service training and continuing medical education (CME).

Medical Director's Signature

As the Service Medical Director for this applicant, I do hereby affirm that the applicant named above meets the criteria to participate in the AEMT Rapid Recertification examinations. In my judgement, the applicant is clinically competent and qualified to continue practicing as an AEMT. I understand this committment is made under the sole authority of my license to practice medicine in the State of New York.

Medical Director's Name (Printed)							
Medical Director's Signature							
License Number:	Date:	Month	Day	Year			

This is a two-sided form; it will not be processed unless both sides are completed, signed and submitted.