Hudson Valley
REMAC

CREDENTIALING RENEWAL APPLICATION

Provider Information (Please Print)

Name: ______ Last Name ______ First Name ______ Middle Initial

Address: ______

______ City ______ State ______ Zip Code

Telephone: ( ) ______ Home ( ) ______ ext. ______ Work ( ) ______ Cell

Date of Birth:	E-Mail:	
NYS AEMT#:	Level of Care: I CC P RSI	HVREMAC#:
Primary ALS Agency*:		Agency Code:

* Note: Change of primary agency requires completion of a change of primary agency document

I affirm that:

1. I have read and agree to abide by the Regional Credentialing Policies as promulgated by the Hudson Valley Regional Emergency Medical Advisory Committee (HVREMAC). I understand that failure to do so may result in the loss of my regional privileges to provide ALS care.
2. I understand that it is my responsibility to advise the Hudson Valley REMAC of any changes in contact information or agency affiliation and that unanswered or unclaimed mail sent via USPS by the REMAC still constitutes a legal notice.
3. The following documentation is attached to this application:

	Document			
ALL LEVEL PROVIDERS	Copy of Valid NYS EMS Certification Card	If not, check one	☐ I have taken a NYS Certification Exam prior to my expiration date and will submit a copy of Card once received.	☐ I applied for renewal through the NYS CME Recertification Program prior to my expiration date.
ALL LEVEL PROVIDERS	Copy of Valid BCLS Card (Front and Back)	OR	As the applicant'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. ______ Instructor's Name (Print) ______ Instructor's Signature ______ Date	
ALL LEVEL PROVIDERS	Copy of Valid PHTLS Card (Front and Back)	If not, check one	☐ I have attended 16 hours of CECBEMS approved Trauma courses.	☐ Satisfied with NYS CME Recertification Program core content
EMT-P EMT-CC	Copy of Valid ACLS Card (Front and Back)			
EMT-P EMT-CC	Copy of Valid PALS Card (Front and Back)			

4. The following Medical Control CME has been completed:

Date	Topic	Instructor	Hours	Date	Topic	Instructor	Hours

ORIGINAL DOCUMENTS MUST BE MAILED OR HAND DELIVERED TO THE HVREMS OFFICE 45 DAYS PRIOR TO THE NYS EMT CERTIFICATE EXPIRATION. FAXED COPIES ARE NOT ACCEPTABLE.

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I hereby certify that all of the information contained in this application is true and correct and that the signature below is mine as the applicant.

Applicant's Signature ________________________ **Date** _____ / _____ / ________

Skills Competency Verification			
	Skills	**QA/QI**	**Direct Observation**
All Level Providers	**Patient Assessment (*Medical and Trauma*)**		
	Airway/Ventilation (*Simple Adjuncts, Advanced Adjuncts, Supplemental Oxygen Delivery, Bag Valve-Mask – one and two rescuer*)		
	Hemorrhage Control & Splinting (*long bone injury, joint injury, traction splinting*)		
	Spinal Immobilization (*Seated and Supine*)		
EMT-I Only	**Cardiac Arrest Management / AED**		
	IV Therapy		
EMT-P EMT-CC	**Cardiac Arrest Management (*Therapeutic Modalities, Mega-code, Monitor/Defibrillator Knowledge*)**		
	IV Therapy / IO/Medication Administration		

As the Physician Medical Director for the Advanced Life Support Agency I hereby affix my signature attesting to the provider's proficiency in all skills outlined above and I reasonably believe that all of the information contained in this application is true and correct.

Agency Medical Director (Print)	**Agency Medical Director Signature**	**Date**

In supporting this application, the Primary Agency hereby affirms:

1. **The ALS provider is currently affiliated as an advanced level pre-hospital care provider for the primary agency.**
2. **It has *<u>ON SITE</u>* documentation attesting to the attendance of the provider at the required number of Continuing Medical Education (CME) hours to renew Hudson Valley Regional ALS credentialing[1].**
3. **It acknowledges that all provider attendance records are subject to audit by the Hudson Valley Regional EMS Office without prior notification and must be produced upon request of an authorized agent of the Hudson Valley REMAC.**

By affixing my signature below, I hereby affirm that I am a duly authorized representative of the provider's Primary Agency; and as such, I am authorized by the agency to affirm to items 1, 2, and 3 above; and I reasonably believe that all of the information contained in this application is true and correct.

Chief Operating Officer or Designee	**Signature**	**Date**

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[1] Twenty-four (24) Hours of Physician Contact attendance is required for a three (3) year or thirty-six (36) month period of credentialing. A term of credentialing less than three (3) years or thirty-six (36) months shall be prorated. All credentialing terms begin after successful completion of the entire testing process, and CME applicable for re-credentialing must have been completed ***after*** that date.