



Hudson Valley Regional Emergency Medical Services Council

45 Academy Avenue~Cornwall On Hudson, NY 12520
(845) 534-2430 ~ fax: (845) 534-3070
www.hvremSCO.org

Agency Revocation of Affiliation Form

Level of Certification:

EMT-Paramedic EMT- Critical Care EMT-Intermediate

NYS EMT Certification # _____ Expiration Date ____ / ____ / _____

Please Type or Print Legibly

Last Name _____ First Name: _____ M.I. _____

Birth date: ____ / ____ / ____ Male Female

Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Primary Phone # _____ Secondary Phone # _____

Please remove the provider referenced above from our agency's affiliation roster immediately;

ALS Agency Name: _____ Agency Code: _____

Name of Primary Agency Representative

Title

Contact Phone #

E mail Address

Date

Signature

If a provider, for any reason, should discontinue an association with the Agency, the Agency shall notify the REMAC of the discontinuation within ten (10) calendar days.

The submission of this form must be accompanied by the Provider's Regional ALS Provider CME file.

All CME attendance records maintained must be provided to the HVREMSCO office for transfer to a new Primary Agency.
