



**Hudson Valley Regional
Emergency Medical Services Council**
45 Academy Avenue ~ Cornwall On Hudson, NY 12520
(845) 534-2430 ~ fax: (845) 534-3070
www.hvremasco.org

Continuing Medical Education Credit Request Form

(To be completed by Applicant)

Name _____

Organization _____

Address _____

Phone # _____ **Fax #** _____ **E- Mail** _____

New York Certification # _____ **MAC #** _____

Title of Course _____

Level of Course BLS ALS

Total Hours Didactic _____ hrs **Total Hours Practical** _____ hrs

Instructor(s) _____

Qualifications/Biography _____

Scheduled Dates/Times _____

Course Location _____

Please submit this form no later than 14 days prior to the scheduled date of the course

To be completed by Regional Office

Date Received: _____ **Date Approved:** _____

Total Credits Approved: _____ **Approval Code:** _____

HVREMAC Authorization: _____ **Initials:** _____
