



Hudson Valley Regional Emergency Medical Services Council

259 Route 17k ~ Newburgh, NY 12550
 (845) 567-6740 ~ fax: (845) 567-6730
 www.hvremSCO.org

Continuing Education Verification Form

Name _____ Agency _____ Date _____
 MAC # _____ AEMT # _____ EMT-I EMT-CC EMT-P

<p style="text-align: center;">CME Lecture/Course</p> <p>Course Location _____</p> <p>Instructor _____</p> <p>Topic/Course _____</p> <p>Time Start _____ End _____</p> <p>Total Hours _____</p>	<p style="text-align: center;">Publication CEU's</p> <p>Publication Name _____</p> <p>Publication Date _____</p> <p>Date Received _____</p> <p>Credits _____</p> <p style="text-align: center;">Must be accompanied by CE certificate</p>
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<p>Medical Control Review .25 each 2.0 max.</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="width: 70%;">Topic</th> <th style="width: 15%;">Yes</th> <th style="width: 15%;">No</th> </tr> </thead> <tbody> <tr> <td>History & Physical Exam Complete</td> <td></td> <td></td> </tr> <tr> <td>Treatment Appropriate</td> <td></td> <td></td> </tr> <tr> <td>Rhythm Strip Interpretation Correct</td> <td></td> <td></td> </tr> <tr> <td>Protocol Adherence</td> <td></td> <td></td> </tr> <tr> <td>Medication Administration Correct</td> <td></td> <td></td> </tr> <tr> <td>Skills Competency Reviewed</td> <td></td> <td></td> </tr> <tr> <td>Clinical Impression Correct</td> <td></td> <td></td> </tr> </tbody> </table> <p>PCR# _____</p> <p>Hospital _____</p> <p>Physician _____</p>	Topic	Yes	No	History & Physical Exam Complete			Treatment Appropriate			Rhythm Strip Interpretation Correct			Protocol Adherence			Medication Administration Correct			Skills Competency Reviewed			Clinical Impression Correct			<p style="text-align: center;">Quality Improvement Medical Control Contact</p> <p>Agency _____</p> <p>Meeting Date _____</p> <p>QI Coordinator _____</p> <p>Agency Med. Dir. _____</p> <hr/> <p style="text-align: center;">Instructor Credits</p> <p>Course Title _____</p> <p>Course Location _____</p> <p>Date(s) _____</p> <p>Instructor ID # _____</p> <p>Program Director _____</p>
Topic	Yes	No																							
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Authorization	
Name _____	Title _____
Level of Certification _____	MD/NP/PA <input type="checkbox"/> MAC Certified <input type="checkbox"/>
_____ Signature	