W e s t c h e s t e r R E M A C

STUDENT CME /CA COMPLETION FORM

Date _____/_____/_____

Name _____ **NYS Certification #** _____

Agency _____ ☐**EMT** ☐**AEMT** ☐**Paramedic**

CALL AUDIT

Time Start _____ Time End _____ Total Time _____

Sponsor Hospital _____ Hospital Code _____

WREMAC OLMC Physician *(Print Name)* _____

WREMAC OLMC Physician *(Sign Name)* _____

PHYSICIAN REVIEW *("Bedside Call Audit") - .25 hr each item, 4hr Max*

PCR/ePCR# _____ **Time of Call** _____ **Agency Code** _____

Clinical Competence	Yes	No	NA	Skill	Yes	No	NA
History Complete	☐	☐	☐	Intravenous Catheter	☐	☐	☐
Physical Exam Complete	☐	☐	☐	Needle Cricothyrotomy.	☐	☐	☐
Appropriate Treatment	☐	☐	☐	Endotracheal Intubation	☐	☐	☐
ECG Interpretation Correct	☐	☐	☐	Chest Decompression	☐	☐	☐
Protocol Compliance	☐	☐	☐	Intraosseous Catheter	☐	☐	☐
Field Diagnostic Testing Completed	☐	☐	☐	Other:_____	☐	☐	☐
Proper Medication Administration	☐	☐	☐	Other:_____	☐	☐	☐
Clinical Impression Correct	☐	☐	☐	Other:_____	☐	☐	☐

Receiving Hospital _____ Hospital Code _____

WREMAC OLMC Physician *(Print Name)* _____

WREMAC OLMC Physician *(Sign Name)* _____

CME LECTURE

Time Start _____ Time End _____ Total Time _____

Hospital / Location _____

Title / Topic _____

Presenter *(Print Name)* _____

Presenter *(Sign Name)* _____

CME COURSE

Time Start _____ Time End _____ Total Time _____

Location _____

Course Type _____ Course # _____

Title / Topic _____ Hours _____

Presenter *(Print Name)* _____

Presenter *(Sign Name)* _____

PUBLICATION CME/CEU *(Completed post-test must be attached to this form for agency record-keeping.)*

☐ EMS Magazine ☐ JEMS ☐ Other *(Print name)* _____

Credits _____

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