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

Original Credentialing Support Form

(To Be Completed by ALS/ILS Agency)

Level of Certification ***(check one)*** ☐ **EMT-Paramedic** ☐ **AEMT**

NYS EMS Certification # _____ **NYS Expiration Date** ____ / ____ / _____

Last Name _____ **First Name** _____ **M.I.** _____

Birth Date _____ / _____ / _____ ☐ **Male** ☐ **Female**

Primary ALS Agency* _____ **Agency Code** _____

*(*Note: Change of primary agency requires notification of REMAC within 10 days to maintain active status. Contact Regional EMS Office for more information.)*

THIS SECTION TO BE COMPLETED BY THE WESTCHESTER REMAC AUTHORIZED ALS / ILS AGENCY

This agency acknowledges the request of the above named individual to change his/her designation of Primary Agency.

In supporting this application, the Agency acknowledges that it is responsible for maintaining Continuing Medical Education (CME) attendance records, Call Audit (CA) attendance records and providing annual reports of such attendance with the Westchester REMAC.

The Agency acknowledges and accepts the responsibility for providing to this applicant any future protocol updates or in-service training required by the Westchester REMAC or REMSCO.

Should the applicant, for any reason, end his or her association with the Agency, the Agency shall notify the REMAC in writing of the termination within ten (10) calendar days. All CME and CA attendance records maintained must then be provided to the applicant for transfer to a new Primary Agency. The Agency will also collect and return any REMAC issued ID.

Name, Primary Agency Chief Operating Officer or QI Coordinator	**Signature**	**Date**

Name, Primary Agency Service Medical Director	**Signature**	**Date**

The ORGINAL copy of this completed form must be MAILED or DELIVERED to:

Westchester REMAC
4 Dana Rd.
Valhalla, NY 10595
ATTN: Provider Credentialing

4 Dana Rd. Valhalla, NY 10595 **P** (914) 231-1616 **F** (914) 813-4161 www.wremsco.org