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

STUDENT CME /CA COMPLETION FORM

Name: _____ **Agency :** _____ **Date:** _____

NYS Certificate #: _____ ☐ **CFR** ☐ **EMT** ☐ **AEMT** ☐ **Paramedic**

CALL AUDIT

Time Start: _____ **Time End:** _____ **Total Time:** _____

Sponsor Hospital: _____ **Hospital Code:** _____

Call Audit Topic: _____

WREMAC OLMC Physician *(Print Name):* _____

WREMAC OLMC Physician *(Sign Name):* _____

CME /COURSE

Title/Topic: _____

Location: _____

Time Start: _____ **Time End:** _____ **Total Time:** _____ **Course #:** _____

Presenter *(Print Name):* _____ **CIC/CLI #:** _____

Presenter *(Sign Name):* _____

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

PCR/Run#: _____ **Time of Call:** _____ **Agency Code:** _____

Receiving Hospital: _____ **Hospital Code:** _____

Note: Assessment, Diagnosis, Treatment and/or Specific Skills reviewed: _____

_____

_____

_____

_____

WREMAC OLMC Physician *(Print Name):* _____

WREMAC OLMC Physician *(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/ Hours:** _____