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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Level of Certification *(check one)*** | | | | | Paramedic | | | | | | | **AEMT** | | | | |
| NYS EMS Certification # | | | | ####### | | | | New Expiration Date | | | | | | MM **/** DD **/** YYYY | | |
|  | | |  | | | | | | | | | | | | | |
| Last Name | | LASTNAME | | | | First Name | | | | FIRSTNAME | | | | | **M.I.** | MIDDLE |
| Birth Date | | **MM / DD / YYYY** | | | | |  | | | Male | | | Female | | | |
|  |  | | | | | | | |  | |  | | | | | |

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| --- | --- | --- | --- |
| **Primary ALS Agency** | ENTER AGENCY | Agency Code | ENTER AGENCYCODE |
| ***(Note: Formal change of primary agency requires completion of a separate document – contact the Regional EMS Office for more information.)*** | | | |

**In supporting this application, the Primary Agency hereby affirms:**

1. **It has, *on site*, documentation attesting to the attendance of the above provider at the required number of Westchester REMAC approved Continuing Medical Education (CME) and Call Audit (CA) hours to renew Westchester Regional ALS credentialing[[1]](#footnote-1), including attendance at any required REMAC updates.**
2. **It acknowledges that all provider attendance records are subject to audit by the Westchester Regional EMS Office without prior notification.**

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|  |  | **OWED[[2]](#footnote-2)** | **COMPLETED[[3]](#footnote-3)** | **NET** |
| ⏵ | Continuing Medical Education (CME) Hours | **ENTER HOURS** | ENTER HOURS | ENTER HOURS |
| ⏵ | **Call Audit (CA) Hours** | **ENTER HOURS** | ENTER HOURS | ENTER HOURS |
|  |  | | | | | |

*The below signed hereby certify that all of the information contained in this application is true and correct.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ENTER CHIEF OPERATING OFFICER |  |  |  | ENTER DATE | |
| **Name, Primary Agency Chief Operating Officer or QI Coordinator** |  | Signature |  | **Date** | |
| **ENTER MEDICAL DIRECTOR** |  |  |  | **ENTER DATE** | |
| **Name, Primary Agency Medical Director** |  | Signature |  | **Date** | |
|  |  |  |  | |  | |

**Completed document(s) should be emailed to the following address: wremsco@wremsco.org**

**Please type “Provider Credentialing” in the subject line. Thank you.**

1. Forty-Eight (48) hours of Continuing Medical Education (CME) and twenty-four (24) Hours of call audit (CA) attendance are required for a three (3) year or thirty-six (36) month period of credentialing. A term of credentialing less than three (3) years or thirty-six (36) months shall be prorated to 1.33 hours of CME and .66 hours of CA per month of the term of credentialing. Any fractional hour requirements shall be rounded to the next *higher* whole number. [↑](#footnote-ref-1)
2. Questions concerning CME/ CA requirements for a specific provider should be directed to the Regional EMS Office at (914) 231-1616. [↑](#footnote-ref-2)
3. All credentialing terms begin after successful completion of the entire testing process, and CME/CA applicable for re-credentialing must have been completed ***after*** that date. [↑](#footnote-ref-3)