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|  | **Westchester REMAC** Original Credentialing Support Form (To Be Completed by ALS Agency) | |
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| **Level of Certification *(check one)*** | | | | | EMT-Paramedic | | | | | | | **AEMT** | | | | |
| NYS EMS Certification # | | | | ###### | | | | NYS Expiration Date | | | | | | **MM / DD / YYYY** | | |
|  | | |  | | | | | | | | | | | | | |
| Last Name | | ENTER LASTNAME | | | | First Name | | | | ENTER FIRSTNAME | | | | | **M.I.** | ENTER MIDDLE |
| Birth Date | | **MM / DD / YYYY** | | | | |  | | | Male | | | Female | | | |
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| **Primary ALS Agency\*** | ENTER AGENCYNAME | | | | | | | Agency Code | | ENTER AGENCYCODE | |
|  | |  |  |  |  |  |  | |  | |  |
| *(\*Note: Change of primary agency requires notification of REMAC within 10 days to maintain active status. Contact Regional EMS Office for more information.)* | | | | | | | | | | | |
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*THIS SECTION TO BE COMPLETED BY THE WESTCHESTER REMAC AUTHORIZED ALS 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.

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| ENTER NAME |  |  |  | ENTER DATE |
| **Name, Primary Agency Chief Operating Officer or QI Coordinator** |  | Signature |  | **Date** |
|  |  |  |  |  |

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| ENTER NAME |  |  |  | ENTER DATE | | |
| **Name, Primary Agency Service Medical Director** |  | Signature |  | **Date** | | |
|  |  |  |  |  | | |
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## *Completed document(s) should be emailed to the following address: wremsco@wremsco.org*

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