NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

Application for AEMT Rapid Recertification

Please print legibly in capital letters or type. Put only one letter or number in each box.

Course Number (Please retain this number for future reference.)

Check if this application is for: ☐ Original Certification ☒ Recertification

This form should only be used for AEMT Rapid Recertification, and must be attached to a Course Memorandum and submitted by an approved course sponsor.

Both sides of this form must be completed and signed.

EMS Identification Number (if you have one)
Write your NYS EMS number in this space

Last Name

First Name and M.I.

Check this box if your name as stated above has changed or is spelled differently than it is on your current EMS card. On the line provided below, enter your name as it appears on your current EMS card. ☐

Address
Number and Street
(Skip one space between number and street)

City State

Zip Code County Date of Birth
MONTH DAY YEAR

Social Security # Sex
(Enter M or F)

On Teaching Faculty Yes ☐ No ☐

If you belong to an EMS agency, please indicate the code in the box(es) below.

Primary EMS Agency Secondary EMS Agency

Day Telephone # – –

Practical Skills Exam Date: 01 03 19
MONTH DAY YEAR

NYS Written Exam Date: 01 17 19
MONTH DAY YEAR

Personal Affirmation **Read carefully before signing**

I do affirm that, in accordance with the requirements of 10 NYCRR 800, I have NOT been convicted of any misdemeanors or felonies. I understand that if I have a conviction it will be individually reviewed and that any such conviction may not be an automatic bar to certification. The Department of Health will determine if the conviction is applicable under the provisions of Part 800.

Do not sign this if you have any convictions.

I hereby certify that all of the information contained in this application is true and correct and that the signature below is mine as applicant. I further understand that offering or providing false information on this document may constitute a crime under the penal law and may subject any certification to revocation or other Department action

Signature of Applicant Date

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Service Medical Director's Affirmation for AEMT Rapid Recertification

THIS SIDE OF FORM SHOULD ONLY BE USED FOR AEMT RAPID RECERTIFICATION

I, _____, serving in the capacity of Service Medical
Name of Service Medical Director
Director for _____ due affirm that
Name of ALS Service
_____ is deemed competent and qualified for admission to the
Name of AEMT Recertification Applicant
State practical skills examination and subsequent State written certification examination in accordance with the State EMS Code (10 NYCRR 800) and the policies and procedures of the Bureau of Emergency Medical Services. I affirm that the applicant meets at minimum all the following criteria:

- **Actively practicing as a New York State certified AEMT within a regionally approved ALS system.**
- **Clinically competent and qualified to practice as an AEMT.**
- **Remains proficient in all of the cognitive and performance objectives of the New York State approved AEMT curriculum.**
- **In the judgement of the Service Medical Director the candidate is of sound character and judgement.**
- **Successfully completed the national cognitive and skills objectives in Basic Cardiac Life Support (BCLS), Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care as outlined in the *Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care: Recommendations of the [most current] National Conference.***
- **Other requirements as set forth by the Service Medical Director.**

The determination of whether a candidate meets the above criteria is made solely by the Service Medical Director and should be based on, but not limited to, direct clinical observation, evaluation of performance through quality improvement/quality assurance activities, in-service training and continuing medical education (CME).

Medical Director's Signature

As the Service Medical Director for this applicant, I do hereby affirm that the applicant named above meets the criteria to participate in the AEMT Rapid Recertification examinations. In my judgement, the applicant is clinically competent and qualified to continue practicing as an AEMT. I understand this committment is made under the sole authority of my license to practice medicine in the State of New York.

Medical Director's Name (Printed) _____

Medical Director's Signature _____

License Number: | | | | | | |

Date: | | | | | | | | Month Day Year

This is a two-sided form; it will not be processed unless both sides are completed, signed and submitted.