

EMPLOYER INFORMATION

Organization in which you are currently employed or volunteer as a Paramedic:

Agency: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Training Officer: _____

Daytime Phone Number: _____

By completing this section, you are indicating that you currently perform Paramedic skills within an emergency medical service, rescue service or patient care facility.

Recertification Form

NRP

INACTIVE STATUS

Request Inactive Status

Inactive status is for those who are currently not providing patient care at their certification level.

CRIMINAL CONVICTION AND DISCIPLINARY ACTION STATEMENTS

YES NO

Since your last certification, have you had a criminal conviction or an Uniform Code of Military Justice action or court martial?

YES NO

Since your last certification, have you ever been subject to limitation, probation, suspension from, or under revocation of your right to practice in a health care occupation or voluntarily surrendered a health care licensure in any state or to any agency authorizing the legal right to work?

ATTENTION

If you answered yes to either question above, you can **NOT** use this form. You must use the online recertification application process.

AFFIRMATION

I hereby affirm that all statements on this application are true and correct. I understand that false statements may be sufficient cause for revocation by the National Registry.

I also understand (please initial each box):

- that this application for renewal of my EMS certification may be selected for audit at any time during my recertification cycle, including AFTER I receive my renewed National Registry certification.
- that email, USPS mail and the message center in my National Registry account are the primary sources of communication from National Registry, and I may receive communication from any or all of these sources regarding audits.
- if selected for audit, within 30 days I must submit documentation that adequately and accurately reflects the EMS education submitted on the recertification application, including but not limited to: course titles, course dates, hours of education, etc.

Your Signature (**must be original**)

Date

ADDITIONAL SIGNATURES (FOR ACTIVE STATUS ONLY)

As a Paramedic Training Officer/Supervisor, I hereby attest to the quality and quantity of the listed continuing education.

Training Officer/Supervisor/Medical Director Signature
(**must be original and different from registrant**)

Date

As a physician medical director of Paramedic training/operations, I hereby attest to the continued competence in all the skills required by the state of licensure and local jurisdictions.

Physician Medical Director Signature
(**must be original and different from registrant**)

Date

DOCUMENT YOUR CONTENT UPDATE AND SKILLS VERIFICATION ON NEXT PAGE

PARAMEDIC CONTENT UPDATE — (60 HRS REQUIRED)

NATIONAL — 30 HOURS

topic	hours	date	method
Airway, Respiration and Ventilation	3.5		
Cardiovascular	8.5		
Trauma	3.0		
Medical	8.5		
Operations	6.5		

LOCAL — 15 HOURS

topic	hours	date	method

INDIVIDUAL — 15 HOURS

topic	hours	date	method

This section must be completed using continuing education hours. You may count 35 hours (10 national, 10 local and 15 individual) of non-instructor-based distributive education toward this section. All hours must be state approved or CAPCE accredited.