CONGRATULATIONS! You have successfully demonstrated continued cognitive competency by examination.

In order to receive recertification, you will need to fill out the enclosed form and answer the information requested. Submission of the enclosed form by someone who has not actually completed the examination process will be considered a fraudulent act and will subject them to disciplinary action according to NREMT policies. YOU MUST complete the entire form in order to be processed. DO NOT send the normal recertification form. ONLY submit the enclosed form that was attached to this letter.

1. Answer the Criminal Conviction and Disciplinary Action questions.

2. Enclose the following:
   a. A copy (front and back) of your current CPR for Healthcare Provider credential.
   b. A copy (front and back) of your current ACLS credential (Paramedic providers only).

3. You will need to sign the application and obtain signatures from the following:
   a. Training Officer / Supervisor of Affiliation
   b. Physician Medical Director of your Affiliation (Advanced Level providers only)

4. Email the form to recertbyexam@nremt.org or mail the completed form to the NREMT:

   NREMT
   Attn. Recert By Exam
   6610 Busch Blvd.
   Columbus, OH 43229

Again, congratulations and we look forward to completing your recertification request. We suggest you submit all materials to the NREMT utilizing some form of traceable delivery means. Please make and retain a copy of ALL materials you sent to NREMT for your own records. Remember, all recertification applications MUST be post-marked no later than March 31st of the year your certification expires.

Drew E. Dawson, BA
Executive Director
THE NATIONAL REGISTRY OF EMERGENCY MEDICAL TECHNICIANS
EMT Cognitive Competency by Exam Form

Since your last registration, have you been convicted of a criminal conviction?

Since your last registration, have you ever been subject to limitation, 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?

If you answered “yes” to either question, you must provide official documentation that fully describes the offense, current status and disposition of the case.

EMPLOYER INFORMATION
Organization in which you currently serve as an EMT:
Agency: _______________________________________________________
Address: _______________________________________________________
City ______________________ State__________ Zip Code ____________
Training Officer _______________________________________________
Daytime Phone # _______________________________________________

By completing this section you are indicating you are currently performing EMT skills in either the emergency ambulance/rescue or patient/health care setting.

VERIFICATION OF SKILL COMPETENCE

<table>
<thead>
<tr>
<th>Skill Category</th>
<th>Medical and Trauma</th>
<th>Simple adjuncts</th>
<th>Supplemental oxygen delivery</th>
<th>Bag-Valve-Mask</th>
<th>One-Rescuer</th>
<th>Two-Rescuer</th>
<th>Automated External Defibrillator (AED)</th>
<th>Seated and lying patients</th>
<th>Radio communications</th>
<th>Report writing &amp; documentation</th>
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</thead>
<tbody>
<tr>
<td>1. PATIENT ASSESSMENT/MANAGEMENT:</td>
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<tr>
<td>2. VENTILATORY MANAGEMENT SKILLS/KNOWLEDGE:</td>
<td>Medical and Trauma</td>
<td>Simple adjuncts</td>
<td>Supplemental oxygen delivery</td>
<td>Bag-Valve-Mask</td>
<td>One-Rescuer</td>
<td>Two-Rescuer</td>
<td>Automated External Defibrillator (AED)</td>
<td>Seated and lying patients</td>
<td>Radio communications</td>
<td>Report writing &amp; documentation</td>
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<td>3. CARDIAC ARREST MANAGEMENT:</td>
<td>Automated External Defibrillator (AED)</td>
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<td>4. HEMORRHAGE CONTROL &amp; SPLINTING PROCEDURES</td>
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<td>5. SPINAL IMMOBILIZATION:</td>
<td>Seated and lying patients</td>
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<td>6. OB/GYNECOLOGIC SKILLS/KNOWLEDGE</td>
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<td>7. OTHER RELATED SKILLS/KNOWLEDGE:</td>
<td>Radio communications</td>
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</table>

As the EMT/Basic Training Director/Supervisor, I do hereby affix my signature attesting to continued competence in all skills outlined above.

Signature of Training Director/Supervisor (must be original signature)

Title

Date Signed

I hereby affirm that all statements on the EMT Recertification form are true and correct, including the copies of cards, certificates and other required verification. It is understood that false statements or documents may be sufficient cause for revocation by NREMT. It is also understood that NREMT may conduct an audit of the recertification activities listed at any time.

Your Signature (must be original signature)

Date Signed

Signature of Training Officer/Supervisor (must be other than Registrant & must be an original signature)

Date Signed