Adirondack-Appalachian Regional EMS Council
P.O. Box 212 • Speculator, NY 12164 • (518) 548-5911

ALS PROCEDURE & CME RECORD

Name _____

EMT # _____

TEK # _____

Agency(ies) Represented _____

_____

Start Date _____ End Date _____

At the end of the 6 month period, please obtain the signatures required below and send this entire booklet to:

Adirondack-Appalachian Regional EMS Council
P.O. Box 212, Speculator, NY 12164

I, the EMT whose signature appears below this statement, acknowledge that the information set forth in this ALS record is true and accurate.

_____ _____
Signature of EMT Date

I, the medical director of the agency for which the above EMT works, do hereby attest that I have reviewed the contents of this record and, to the best of my knowledge, believe this EMT to be competent in the skills required of an EMT practicing at the _____ level.

_____ _____
Signature of Medical Director Date

I V

REGIONAL REQUIREMENTS – Two successful IVs every six months (Jan.-June & July-Dec.) (I/CC/P)

Date	Patient or Practice	Pediatric or Adult	Attending Signature / Title
	❑ Patient ❑ Practice PCR #	❑ Infant (<1) ❑ Child (1-8) ❑ Adult	
	❑ Patient ❑ Practice PCR #	❑ Infant (<1) ❑ Child (1-8) ❑ Adult	

ENDOTRACHEAL INTUBATION

REGIONAL REQUIREMENTS – Two successful adult and two successful pediatric intubations every six months (Jan.-June & July-Dec.) (I/CC/P)

Date	Patient or Practice	Pediatric or Adult	Attending Signature / Title
	❑ Patient ❑ Manikin PCR #	❑ Infant (<1) ❑ Child (1-8) ❑ Adult	
	❑ Patient ❑ Manikin PCR #	❑ Infant (<1) ❑ Child (1-8) ❑ Adult	
	❑ Patient ❑ Manikin PCR #	❑ Infant (<1) ❑ Child (1-8) ❑ Adult	
	❑ Patient ❑ Manikin PCR #	❑ Infant (<1) ❑ Child (1-8) ❑ Adult	

DEFIBRILLATION

REGIONAL REQUIREMENTS – Two adult defibrillations every six months (Jan.-June & July-Dec.) (EMT-D, AEMT-I/CC/P)

Date	Patient or Practice	Age	Pediatric or Adult	Attending Signature / Title
	❑ Patient ❑ Manikin PCR #		❑ Defib ❑ Cardiovert ❑ AED ❑ Manual	
	❑ Patient ❑ Manikin PCR #		❑ Defib ❑ Cardiovert ❑ AED ❑ Manual	

MISC. ALS PROCEDURES
(IO, NEEDLE CHEST DECOMPRESSION, ETC.)

REGIONAL REQUIREMENTS – One IO every year (CC and P)

Date	Patient or Practice	Patient Age	Procedure Performed	Attending Signature / Title
	❑ Patient ❑ Manikin PCR #			
	❑ Patient ❑ Manikin PCR #			

INSERVICE EDUCATIONAL PROGRAM

REGIONAL REQUIREMENTS - Six hours every six months (Jan.-June & July-Dec.) (EMT-D, AEMT-I/CC/P) - Please record only 6 hours

Date	Time (Hours)	Location	Topic	Attending Signature / Title