NATIONAL REGISTRY OF EMERGENCY MEDICAL TECHNICIANS
EMT - Basic Reregistration Report 2006

Please read instructions on page 4

Registry Number B

Social Security Number

Last Name

First Name

Mid. Init.

Mailing Address

City

State

Zip + 4

Email

Home Phone

Area Code

YES ◯ NO ◯ Since your last registration, have you been convicted of a felony?

YES ◯ NO ◯ Have you ever been subject to limitation, suspension for, 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.

Name and address of organization in which you serve as an EMT-Basic:

Agency: _____

Address: _____

City _____ State _____ Zip Code _____

Training Officer _____

Daytime Phone #_____

I am currently performing EMT-Basic skills in either the emergency ambulance/ rescue or patient/health care setting.

◯ Currently working

◯ Request inactive status*

*Refer to page 4

FOR OFFICE USE ONLY

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ATTACH CHECK/MONEY ORDER HERE

SECTION IA: EMT BASIC REFRESHER TRAINING - 24 HOURS*

Dates Completed	Division	Hrs Req	Hrs Rec	Method Used	Dates Completed	Division	Hrs Req	Hrs Rec	Method Used
	Preparatory	1				Trauma	4		
	Airway	2				OB,Infs&Child	2		
	Pt. Assessment	3				Elective	8		
	Med/Behavioral	4				TOTAL HRS	24		

* Send copy of your course completion certificate from state approved EMT Basic Refresher.
If a formal refresher was not completed, fill out Section 1A, applying continuing education dates, hours and method used in the appropriate areas above. Refer to instructions page 4.

SECTION IB: CPR CERTIFICATION

As the registrant's CPR Instructor/Training Officer, I hereby verify the registrant has been examined and performed satisfactorily so as to be deemed competent in each of the following:

Adult 1 & 2 Rescuer CPR
Adult Obstructed Airway
Child CPR
Child Obstructed Airway
Infant CPR
Infant Obstructed Airway

Verifying Signature
Submit copy of card and/or verify with appropriate signature.

EMT's CPR EXP DATE Month — Year

SECTION II: ADDITIONAL 48 HOURS OF CONTINUING EDUCATION

Date Comp.	Topics of Training	Method Used	Hours Rec'd	Date Comp.	Topics of Training	Method Used	Hours Rec'd
						TOTAL HOURS	

SECTION III: VERIFICATION OF SKILL MAINTENANCE	Q/A: Q/I	Direct Observation	Other
1. PATIENT ASSESSMENT/MANAGEMENT: Medical and Trauma			
2. VENTILATORY MANAGEMENT SKILLS/KNOWLEDGE: Simple adjuncts Supplemental oxygen delivery Bag-Valve-Mask One-Rescuer Two-Rescuer			
3. CARDIAC ARREST MANAGEMENT: Automated External Defibrillator (AED)			
4. HEMORRHAGE CONTROL & SPLINTING PROCEDURES			
5. SPINAL IMMOBILIZATION: Seated and lying patients			
6. OB/GYNECOLOGIC SKILLS/KNOWLEDGE			
7. OTHER RELATED SKILLS/KNOWLEDGE: Radio communications Report writing & documentation			

As the EMT-Basic Training Program Director, Service Director of Operations or the Physician Medical Director, I do hereby affix my signature attesting to continued competence in all skills outlined in Section III.

Signature of Training Director, Service Director of Operations or Physician Director *(must be original signature)* | Title | Date Signed

I hereby affirm that all statements on the EMT-Basic Reregistration Report 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 reregistration activities listed at any time.

Signature of Registrant *(must be original signature)* | Date Signed

Signature of Training Officer/Supervisor of Affiliation *(Must be other than Registrant & must be original signature)* | Date Signed