INSTRUCTIONS FOR REPORT OF EMT- PARAMEDIC CONTINUING EDUCATION

Part of State Form 18220 (R12 / 7-13)
DEPARTMENT OF HOMELAND SECURITY

I. Certification as an emergency medical technician-paramedic will be valid for a period of two years.

II. To renew a certification, a certified paramedic shall submit a report of continuing education every two (2) years that meets or exceeds the minimum requirements below.

A. An applicant shall report a minimum of seventy-two (72) hours of continuing education consisting of the following:

1. Section IA - Forty-eight (48) hours of continuing education through a formal paramedic refresher course as approved by the commission or forty-eight (48) hours of supervising hospital-approved continuing education that includes the following:

a. Sixteen (16) hours in airway, breathing, and cardiology

b. Eight (8) hours in medical emergencies

c. Six (6) hours in trauma

d. Sixteen (16) hours in obstetrics and pediatrics

e. Two (2) hours in operations

2. Section IB - Attach a current copy of cardiopulmonary resuscitation certification for the professional rescuer. The certification expiration date shall be concurrent with the paramedic certification expiration date.

3. Section IC - Attach a current copy of advanced cardiac life support certification. The certification expiration date shall be concurrent with the paramedic certification expiration date.

4. Section II - Twenty-four (24) additional hours of emergency medical services related continuing education; twelve (12) of these hours shall be obtained from audit and review. The participation in any course as approved by the commission may be included in this section.

5. Section III - Skill maintenance (with no specified hour requirement) - All skills shall be directly observed by the emergency medical service medical director or emergency medical service educational staff of the supervising hospital, either at an in-service or in an actual clinic setting. The observed skills include, but are not limited to, the following:

a. Patient medical assessment and management

b. Trauma assessment and management

c. Ventilatory management

d. Cardiac arrest management

e. Bandaging and splinting

f. Medication administration, intravenous therapy, intravenous bolus, and intraosseous therapy

g. Spinal immobilization

h. Obstetrics and gynecological scenarios

i. Communication and documentation

Reset Form

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DEPARTMENT OF HOMELAND SECURITY

REGISTRANT INFORMATION

Public safety identification number	Indiana certification number	Driver's license number

Printed name (*last, first, middle initial*)	Home telephone number ( )	E-mail address

Home address (*number and street, city, state, and ZIP code*)

Have you been trained in NIMS / ICS?	If yes, level of NIMS / ICS training:	Would you be willing to assist in a disaster?
☐ Yes ☐ No	☐ 100 ☐ 200 ☐ 300 ☐ 400 ☐ 700 ☐ 800 ☐ Other _____	☐ Yes ☐ No

VIOLATION STATEMENT

Have you ever been arrested for or convicted of a crime that has not been expunged by a court (excluding minor traffic violations)? ☐ Yes ☐ No	*If you answered yes, you must attach official documentation that fully describes the offense, current status, and disposition of the case.*

SIGNATURE OF EMS MEDICAL DIRECTOR

As the EMS Medical Director, I do hereby affix my signature attesting to the continued competence in all skills outlined in Section III of this document.

Signature of physician	Printed name of physician	Date (*month, day, year*)

License number	State	Telephone number ( )

Signature of physician	Printed name of physician	Date (*month, day, year*)

License number	State	Telephone number ( )

SIGNATURE OF EMS REGISTRANT

I, the undersigned paramedic, hereby affirm, under the penalty for perjury, that all statements on this continuing education report are true and correct, including copies of cards, certificates, and other required documents for verification. I understand that false statements or documents may be sufficient cause for revocation by the Indiana Department of Homeland Security and the Emergency Medical Services Commission. I also understand that the Indiana Department of Homeland Security and the Emergency Medical Services Commission may conduct an audit of the recertification activities listed at any time.

Signature of paramedic	Date (*month, day, year*)

CURRENT AFFILIATIONS - AMBULANCE PROVIDER ORGANIZATIONS

Name of provider	Provider certification number	Telephone number ( )

Street address (*number and street, city, state, and ZIP code*)

Signature of Chief Executive Officer	Date (*month, day, year*)

Name of provider	Provider certification number	Telephone number ( )

Street address (*number and street, city, state, and ZIP code*)

Signature of Chief Executive Officer	Date (*month, day, year*)

CURRENT AFFILIATIONS - SUPERVISING HOSPITAL

Name of hospital	Telephone number ( )

Street address (*number and street, city, state, and ZIP code*)

Signature of EMS Coordinator	Date (*month, day, year*)

Name of hospital	Telephone number ( )

Street address (*number and street, city, state, and ZIP code*)

Signature of EMS Coordinator	Date (*month, day, year*)

SECTION IA: EMT - PARAMEDIC REFRESHER TRAINING

1. If a formal EMT-Paramedic Refresher course was completed, please attach a copy of the certificate of completion.
2. If a formal EMT-Paramedic Refresher course was not completed, Section I must be completed in its entirety. All signatures must be original.
3. All in-services and refresher courses must be done at or approved by your Supervising Hospital.
4. Lecture hours can only be assigned to one category of in-service credit in Section I.

DATE *(month, day, year)*	NUMBER OF HOURS	TOPIC	INSTRUCTOR'S SIGNATURE
Division I - Airway, Breathing, and Cardiology			**Required: 16 hours**
Division II - Medical Emergencies			**Required: 8 hours**
Division III - Trauma			**Required: 6 hours**
Division IV - Obstetrics & Pediatrics			**Required: 16 hours**
Division V - Operational Tasks			**Required: 2 hours**

SECTION IB: CPR CERTIFICATION	SECTION IC: ACLS CERTIFICATION
Attach a copy of the front of your current provider card or certification.	*Attach a copy of the front of your current provider card or certification.*

CPR and ACLS certification hours may be added to the appropriate divisions in Sections I and II.

SECTION II: 24 ADDITIONAL HOURS OF CONTINUING EDUCATION

12 hours must be obtained as AUDIT & REVIEW

DATE *(month, day, year)*	NUMBER OF HOURS	TOPIC	INSTRUCTOR'S SIGNATURE

SECTION III: VERIFICATION OF SKILL COMPETENCE

1. No specific amount of time must be spent on each skill or combination thereof.
2. All skills must be directly observed by the EMS Medical Director or EMS educational staff of the Supervising Hospital, either at an in-service or in an actual clinical setting. All signatures must be original.

SKILL	DATE *(month, day, year)*	INSTRUCTOR'S SIGNATURE
A. Medical Assessment / Management		
B. Trauma Assessment / Management		
C. Ventilatory Management		
D. Cardiac Arrest Management		
E. Bandaging and Splinting		
F. Medication Administration, IV Therapy, IV Bolus, and IO Therapy		
G. Spinal Immobilization		
H. Obstetrics and Gynecological		
I. Communication and Documentation		