



**Connecticut Department of Public Health
Office of Emergency Medical Services**



Uniform EMS Continuing Education Certificate

Participant Information					
Name:					
Level of Provider:	<input type="checkbox"/> EMR	<input type="checkbox"/> EMT	<input type="checkbox"/> Advanced EMT	<input type="checkbox"/> Paramedic	<input type="checkbox"/> EMS Instructor
EMS Certification #:			Expiration:		
Continuing Education Information					
Date:					
Title/Topic:					
Location:					
Start Time:		End Time:		Total CME Hours:	
Approval #:					
Instructor Name:			Instructor EMS-I #:		
If Instructor is not a certified EMS-I, list qualification:					
Suggested NREMT NCCR Category					
<input type="checkbox"/> Airway, Respiratory, Ventilation	Ventilation, Capnography, Oxygenation, Skills				
<input type="checkbox"/> Cardiovascular	Post Resuscitation Care, Stroke, Cardiac Arrest, Pediatric Cardiac Arrest, Ventricular Assist Devices, Congestive Heart Failure, Acute Coronary Syndromes				
<input type="checkbox"/> Trauma	Trauma Triage, CNS Injury, Hemorrhage Control, Fluid Resuscitation				
<input type="checkbox"/> Medical	Special Healthcare Needs, Obstetrical Emergencies, Infectious Disease, Medication Delivery, Pain Management, Psychiatric, Toxicology, Neurology, Endocrine, Immunological				
<input type="checkbox"/> Operations	At Risk Populations, Ambulance Safety, Field Triage, Hygiene & Vaccinations, Culture of Safety, Pediatric Transport, Crew Resource Management, Research, Evidence Based Guidelines				
<input type="checkbox"/> General CME	Any EMS related topic that may be applied to the Local or Individual Requirement				
Certification					
Instructor	I certify that this is a true and accurate record of the above named person participating in an approved EMS continuing education program for the listed number of hours. If this program is identified as a National Continued Competency Requirement (NCCR) program, I certify that the program was presented according to the current outline provided by the National Registry of EMTs.				
Signature			Date:		
Participant	I certify that this is a true and accurate record of my participation in this approved EMS continuing education program and that I participated for the number of hours listed. I will maintain a copy of this certificate for audit by the Department of Public Health, Office of Emergency Medical Services, and will upload a copy to my NREMT.org training portal (when available).				
Signature			Date:		

Check when entered in NREMT.org