



W e s t c h e s t e r R E M A C
CME /CA ATTENDANCE SHEET

Date ____ / ____ / ____

Call Audit CME Topic/Title _____

Time Start _____ Time End _____ Total Time _____

Location _____

Sponsor Hospital _____ Hospital Code _____

	Print Name	NYS EMT #	EMT			Primary Agency	Sign In	Sign Out
			B	I	P			
1								
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I certify that the above listed personnel attended and completed the program identified above.

Physician / Instructor (*Print Name*) _____

Physician / Instructor (*Sign Name*) _____

NOTE: FAX or MAIL this form to the Regional EMS Office on the first business day following the program.

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