



W e s t c h e s t e r R E M A C
STUDENT CME /CA COMPLETION FORM

Date _____/_____/_____

Name _____ NYS Certification # _____
Agency _____ EMT-B EMT-I EMT-P

CALL AUDIT

Time Start _____ Time End _____ Total Time _____
Sponsor Hospital _____ Hospital Code _____
WREMAC OLMC Physician (Print Name) _____
WREMAC OLMC Physician (Sign Name) _____

PHYSICIAN REVIEW ("Bedside Call Audit") - .25 hr each item, 4hr Max

PCR/ACR#	Time of Call			Skill	Agency Code		
	Yes	No	NA		Yes	No	NA
Clinical Competence							
History Complete	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intravenous Catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Exam Complete	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Needle Cricothyrotomy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appropriate Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endotracheal Intubation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ECG Interpretation Correct	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest Decompression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Protocol Compliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intraosseous Catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Field Diagnostic Testing Completed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Proper Medication Administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Impression Correct	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Receiving Hospital _____ Hospital Code _____
WREMAC OLMC Physician (Print Name) _____
WREMAC OLMC Physician (Sign Name) _____

CME LECTURE

Time Start _____ Time End _____ Total Time _____
Hospital / Location _____
Title / Topic _____
Presenter (Print Name) _____
Presenter (Sign Name) _____

CME COURSE

Time Start _____ Time End _____ Total Time _____
Location _____
Course Type _____ Course # _____
Title / Topic _____ Hours _____
Presenter (Print Name) _____
Presenter (Sign Name) _____

PUBLICATION CME/CEU (Completed post-test must be attached to this form.)

EMS Magazine JEMS Other (Print name) _____
Credits _____