



# Paramedic License Renewal Application

## Idaho Emergency Medical Services Bureau



Send completed form to Idaho EMS Bureau, PO Box 83720, Boise, ID 83720-0036 or  
Fax to 208-334-4015

**Completion checklist:**  \$25 renewal fee  Application  Completed continuing education record

**Required Signatures:**  Applicant Signature  Affiliating Agency Official Signature  Medical Director Skills Verification Signature

**Supporting Documentation:**  LZO Course Completion Documentation  Refresher Course Completion Documentation  Pediatric Specific CEU's

**Applicant Information:**

Social Security # \_\_\_\_\_ - - Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Drivers License # \_\_\_\_\_ DL State \_\_\_\_\_

Name \_\_\_\_\_ Gender  F  M

Last Name First Name Middle Name/Initial

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Circle the highest level of education: GED High School Diploma College: 1 2 3 4 5 6 7 8

**Affiliation:**

Agency Name \_\_\_\_\_ Agency License # \_\_\_\_\_

Agency Chief/Director/President \_\_\_\_\_

**Signature** Printed Name

Additional Licensed EMS Affiliations: \_\_\_\_\_

Check all circumstances in which you will use this certification:

|                                      |                                    |
|--------------------------------------|------------------------------------|
| <u>Volunteer</u>                     | <u>Career</u>                      |
| <input type="checkbox"/> True        | <input type="checkbox"/> Full Time |
| <input type="checkbox"/> Compensated | <input type="checkbox"/> Part Time |

**Applicant Signature:**

I hereby affirm the information herein is true and correct, and that I meet all requirements for EMS licensure as established by the State of Idaho.

\_\_\_\_\_  
**Signature of Applicant**

\_\_\_\_\_  
Date signed

**For Bureau Use Only**

|                               |   |
|-------------------------------|---|
| Received in Bureau            | Cert. Fee Rcvd Date _____                       |
|                               | <input type="checkbox"/> Cash - Receipt # _____ |
|                               | <input type="checkbox"/> Check # _____          |
|                               | <input type="checkbox"/> M.O. # _____           |
|                               | <input type="checkbox"/> DB - Agency _____      |
| Received by Licensure Program |   |

**Paramedic  
License Renewal Education Record**

**Applicant Name:** \_\_\_\_\_

**Additional Continuing Education** (required if your license expires **after** 09/30/10) – Attach proof of completion

Landing Zone Officer training Date \_\_\_\_\_ Instructor \_\_\_\_\_

Record the number of hours accumulated during the current certification period in each category based on the method utilized. Total all hours across and down. Renewal requires 6 of 9 venues and at least 4 hours in all categories and an additional four hours in Pediatric specific, with a minimum of 72 hours total.

| <b>Assurance of Knowledge Categories</b> | <b>Classroom Sessions</b> | <b>Refresher Program</b> | <b>Nationally Recognized Courses</b> | <b>Regional and National Conferences</b> | <b>Teaching Topical Material</b> | <b>Approved Self-study or Directed Study</b> | <b>Case Reviews or Grand Rounds</b> | <b>Formal Distance Learning</b> | <b>Journal Article Review</b> | <b>Total Hours in Each Category</b> |
|--|---------------------------|--------------------------|--------------------------------------|--|----------------------------------|--|-------------------------------------|---------------------------------|-------------------------------|-------------------------------------|
| Landing Zone Officer                     |                           |                          |                                      |  |                                  |  |                                     |                                 |                               |                                     |
| Assessment Based Management              |                           |                          |                                      |  |                                  |  |                                     |                                 |                               |                                     |
| Airway Management/Ventilation            |                           |                          |                                      |  |                                  |  |                                     |                                 |                               |                                     |
| Emergency Pharmacology                   |                           |                          |                                      |  |                                  |  |                                     |                                 |                               |                                     |
| Trauma                                   |                           |                          |                                      |  |                                  |  |                                     |                                 |                               |                                     |
| Medical                                  |                           |                          |                                      |  |                                  |  |                                     |                                 |                               |                                     |
| <b>Pediatrics (At least eight hours)</b> |                           |                          |                                      |  |                                  |  |                                     |                                 |                               |                                     |
| Special Considerations                   |                           |                          |                                      |  |                                  |  |                                     |                                 |                               |                                     |
| EMS Systems                              |                           |                          |                                      |  |                                  |  |                                     |                                 |                               |                                     |
| <b>Total hours in each venue:</b>        |                           |                          |                                      |  |                                  |  |                                     |                                 |                               | <b>Grand Total</b>                  |

**Skills Verification-** As the Physician Medical Director for the above named ALS Agency, I attest to the competence of the applicant named on this form in all of the Assurance of Knowledge and Skills Proficiency categories listed on this page and recommend license renewal of this individual.

- *Cardiac Rhythm Interpretation including the ability to correctly interpret oscilloscopic and hard copy electrocardiograms*
- *History Taking*
- *Medical Assessment and Management*
- *Trauma Assessment and Management*
- *Advanced Cardiac Arrest Management*
- *Pediatric and Infant Resuscitation to include airway obstruction*
- *Basic Airway Management to include bag-valve-mask and bag-valve tube ventilation*
- *Advanced Airway Management to include endotracheal intubation*
- *Emergency Medical Systems Medical Communications involving voice and ECG telemetry communications procedures including actions during communications failures*
- *Fracture Immobilization including traction splinting*
- *Intravenous Therapy*
- *Parenteral Drug Administration*
- *CPR proficiency/AED awareness*
- *Spinal Immobilization seated and supine including application of the cervical collar*
- *Obstetrics Delivery Procedures to include care of the newborn*

\_\_\_\_\_  
Signature of Agency Medical Director

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Agency Medical Director