



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:

<i>Volunteer</i>	<i>Career</i>
<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 (Must be completed prior to September 30, 2010) – 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.

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

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 or Designee

Date

Printed Name of Agency Medical Director or Designee