NOR-CAL EMS	2402	Initial Paramedic Accreditation Form

Nor-Cal EMS Policy & Procedure Manual	Certifications
Effective Date:	Next Revision:
Approval: Jeffrey Kepple MD – MEDICAL DIRECTOR	SIGNATURE ON FILE

This form must be completed and submitted within **forty-five (45) days** of receiving the Accreditation packet and test date from Nor-Cal EMS

Name:	E-mail:	Phone:
CA Paramedic License #	Expiration Date:	
Primary Employer:		
Employer #2:		

Required Trainings	Training Date
Continuation of Antibiotics 1701	
Chest Pain- 1104 (Destination Decision focus)	
Continuous Quality Improvement (CQI) Policies and Procedures	
Cricothyroidotomy Treatment guidelines	
Determination of Death Policy- 1108 / 1109	
Do Not Resuscitate Policy	
Endotracheal Intubation Policy and Mandatory Metrics	
Interfacility Transfer Policy	
Needle Thoracostomy Policy	
Refusal of Care / Release at Scene Policy- 1200	
Sedation Treatment Guideline	
Spinal Motion Restriction Treatment Guideline- 1301	
Supraglottic Protocol and Mandatory Metrics	
Stroke- 1106	
Trauma Treatment Guidelines 1302/1303	
Unusual Occurrence Report 3009 / Incident Report Form 3009A	
Heparin Treatment Guideline- 1707	
IV Nitroglycerin Treatment Guideline- 1706	
Continuation of Blood Products Treatment Guideline 1702	
Review of Region III MCI Plan – Manuals 1 & 2 (See NorCal Website)	

Supervised field evaluation/Orientation Shifts with an approved preceptor, minimum of 3 shifts (12 or 24 hours), Completing a minimum of 5 ALS calls or simulations. To include at a minimum 1 each (Chest Pain (STEMI Destination decision), Trauma(Destination decision/SMR decision), Stroke (Destination decision) Mega Code, Pediatric Mega Code, Refusal of care.
Number of calls___ Simulations ____ ❑ This requirement was waived by LEMSA

I am an authorized representative for (Name of Provider Agency) provider agency.

The above named Paramedic has successfully completed all required courses and trainings for Initial Accreditation in the Nor-cal EMS region.

Employer Signature:	***Date:***
Print Name:	***Title:***

NOR-CAL EMS USE ONLY:	Application completed	Date:
	Testing Date:	Score:
	Repeat Test Date:	Score: