


| | | |
|--|-----------------------|---|
|  | 2402 | Initial Paramedic Accreditation Form |
| Nor-Cal EMS Policy & Procedure Manual | Certifications | |
| Effective Date: 10/03/2022 | 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) | | |
| <p>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: 1-Chest Pain (STEMI Destination decision) 2-Trauma(Destination decision/SMR decision) 3-Stroke (Destination decision) 4-Mega Code 5-Pediatric Mega Code 6-Refusal of care (RAS vs AMA) Number of calls ___ Simulations ___ <input type="checkbox"/> This requirement was waived by LEMSA</p> | | |
| <p>I am an authorized representative for (<i>Name of Provider Agency</i>) provider agency. The above-named Paramedic has successfully completed all required courses and trainings for Initial Accreditation in the Nor-Cal EMS region.</p> | | |
| Employer Signature: | | Date: |
| Print Name: | | Title: |
| NOR-CAL EMS USE ONLY: | Application completed | Date: |
| | Testing Date: | Score: |
| | Repeat Test Date: | Score: |