NOR-CAL EMS	2402	Initial Paramedic Accreditation Form

Nor-Cal EMS Policy & Procedure Manual	Certifications
Effective Date: 11/01/2025	Next Revision: 11/2028
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.*

Name:	E-mail:	Phone:
CA Paramedic License #	Expiration Date:	
Primary Employer:	Employer #2 (if applicable):	

Required Trainings	Training Date
Continuation of Antibiotics- **1701**	
Chest Pain- **1104** (Destination Decision Focus **3106**)	
Continuous Quality Improvement (CQI) Policies and Procedures- **3501**	
Cricothyroidotomy Treatment guidelines- **1204 & 6303**	
Determination of Death Policy- **1108**	
Do Not Resuscitate Policy- **1109**	
Endotracheal Intubation Policy and Mandatory Metrics- **1102 & "Forms"**	
High Flow Nasal Canula- **1203, 1708, & 1836**	
Interfacility Transfer Policy-**1700**	
Needle Thoracostomy Policy-**1302 &1828 & 6304**	
Refusal of Care / Release at Scene Policy- **1200**	
Sedation for Pain & Sedation for Behavioral Health Crises Treatment Guideline-**1202 & 1212**	
Spinal Motion Restriction Treatment Guideline- **1301**	
Supraglottic Protocol and Mandatory Metrics- **3102 & 6302 & "Forms"**	
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**	
Nor-Cal EMS MCI Plan **– 1304**	

Supervised field evaluation/Orientation Shifts with an approved preceptor, minimum of three (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 ____ ❑ 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 training courses 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: