Hamilton Health Sciences
CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH

INITIAL CERTIFICATION REQUEST FORM

1. **Paramedic: Complete Part A, B, C, D, E. Submit form to your service**
2. **Paramedic Service: Complete Part F.**
3. **Submit to CPER electronically** education@cper.ca

SERVICE TO SUBMIT WHEN COMPLETE

PART A: Paramedic Information		
First Name:	Last Name:	
OASIS #:	Email:	
Address 1:	City:	
Address 2:	Province:	Postal Code:
Home Phone #:	Cell Phone #:	

PART B: Education History	
Primary Care Paramedic Program	**Advanced Care Paramedic Program**
University/College Name:	University/College Name:
City & Province:	City & Province:
Program Title:	Program Title:
Year of Graduation:	Year of Graduation:

PART C: Employment History (past and present)	
Most Recent Employment	
Employer Name:	Level of Certification: ☐ PCP ☐ PCP IV ☐ ACP
Base Hospital:	
Date Employed:	Last Day of Work:
Other Employment	
Employer Name:	Level of Certification: ☐ PCP ☐ PCP IV ☐ ACP
Base Hospital:	
Date Employed:	Last Day of Work:

PART D: Certification Eligibility Under Ontario Reg. 257/00	
Document	**Date Issued**
MOH ACP Certificate #:	
MOH AEMCA Certificate #:	

PART E: Release of Information Authorization

Have you ever been deactivated or decertified by a Medical Director for issues surrounding your Paramedic Certification, not including absence from clinical practice (e.g. Maternity Leave, Leave of Absence)?

☐ Yes ☐ No

Reason:

I authorize the release of the information provided above to the Centre for Paramedic Education and Research (CPER), via my employer and/or college. I authorize my employer, college and/or Base Hospital(s) to discuss my case with respect to all of my files with CPER and to retain a copy of this form on file.

Paramedic Signature: Date:

THIS SECTION IS TO BE FILLED OUT BY YOUR SERVICE

PART F: Certification Request (initial certification)

Paramedic Service:	
Paramedic Name:	Oasis #:
Current Certification Level: ☐ PCP ☐ PCP IV ☐ ACP	Requested Certification Level: ☐ PCP ☐ PCP IV ☐ ACP
Offer of Employment Date/Start Date:	

I attest that this individual meets all the requirements for certification to perform controlled acts as outlined in Ontario Regulation 257/00 and have all required documents on file.

Name:
Position:
Signature:
Date:

Hamilton Health Sciences
CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH

PART I: Referral Base Hospital Information

Paramedic Name:	Oasis #:
To: Medical Director	Base Hospital:
From: Medical Director	Base Hospital:

PART G: Certification History

Initial Paramedic Certification

Date: Base Hospital: ☐ PCP ☐ ACP

Last Paramedic Recertification

Date: Base Hospital: ☐ PCP ☐ ACP

Has this Paramedic ever been deactivated or decertified by a Medical Director for issues surrounding their Paramedic Certification, not including absence from clinical practice (i.e. Maternity Leave, Leave of Absence)?

☐ Yes ☐ No

Reason:

PART H: Currently Held Auxiliary Certification

Medical Directive List	PCP	ACP	Medical Directive List	PCP	ACP
Administration of Antidotes for Cyanide Exposure	☐	☐	Hydrofluoric Acid Exposure	☐	☐
Administration of Atropine, either Pralidoxime Chloride (2 pam) or Obidoxime and Diazepam for Nerve Agent Exposure	☐	☐	Pediatric Administration of Atropine, either Pralidoxime Chloride (2 pam) or Obidoxime and Diazepam for Nerve Agent Exposure	☐	☐
Adult Intraosseous Device:		☐	Symptomatic Riot Agent Exposure	☐	☐
Procedural Sedation		☐	Manual Defibrillation	☐	☐
Central Venous Access Device		☐	Nausea/Vomiting Route:	☐	☐
Combative Patient		☐	Emergency Dialysis Disconnect	☐	☐
Continuous Positive Auxiliary Pressure Device:	☐	☐	Supraglottic Airway Device:	☐	☐
Cricothyrotomy Device:		☐	Intravenous + Fluid Therapy - Autonomous	☐	☐
Electronic Control Device Probe Removal	☐	☐	12 Lead Interpretation	☐	☐
Diphenhydramine:	☐	☐	Other:	☐	☐

CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH USE ONLY	
Date Received:	Request Type:
File Reviewed Date:	File Reviewed By:
Certification Letter Issued On:	