

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	2:	
Home Phone #:	Cell Phone #:			
L	L			
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:			
	L			
PART C: Employment History (past and present)				
Most Recent Employment				
Employer Name:	Level of Certification: PC	Р 🗆 РСР	IV 🗆 ACP	
Base Hospital:				
Date Employed:	Last Day of Work:			
Other Employment				
Employer Name:	Level of Certification: PC	P 🗆 PCP	IV	
Base Hospital:				
Date Employed:	Last Day of Work:			
PART D: Certification Eligibility Under Ontario Reg. 257/0	0			
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 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:	Requested Certification Level:						
Offer of Employment Date/Start Date:							
I attest that this individual meets all the requirements for certification thave all required documents on file.	o perform controlled acts as outlined in Ontario Regulation 257/00 and						

Name:

Position:

Signature:

Date:



Oasis #:

PART I: Referral Base Hospital Information

Paramedic Name:

To: Medical Director		Base Hospital:				
From: Medical Director			Base Hospital:			
DART C. Contiliention History						
PART G: Certification History Initial Paramedic Certification						
			□ pcp			
Date: Base Hospital:			□ РСР	☐ ACP		
Last Paramedic Recertification				☐ ACP		
Date: Base Hospital: 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	ermey Lee	ive, Leav	e of Albacifice).			
Reason:						
PART H: Currently Held Auxiliary Certificat						
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 PARAM	MEDIC I	EDUC <i>A</i>	ATION AND RESEARCH USE ONLY			
Date Received:			Request Type:			
File Reviewed Date:			File Reviewed By:			
Certification Letter Issued On:						