Hamilton Health Sciences
CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH

RETURN TO CLINICAL PRACTICE REQUEST FORM

To submit to CPER, please email completed form to

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: Certification Request Return to Practice Service

Paramedic Service:	
Paramedic Name:	OASIS #:
Current Certification Level: ☐ PCP ☐ PCP IV ☐ ACP	
Projected RTCP Date:	
Last Day of Clinical Activity:	
Other Considerations	

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:

CENTRE FOR PARAMEDIC EDUCATION AND RESEARCH USE ONLY

Date form received:	Certification Letter Issued Date:
Last APR:	Certification Date for PCP IV Certification:
Certification MoC exams Complete:	Certification Filed Date: