EMERGENCY MEDICAL TECHNICIAN
CONTINUING EDUCATION DOCUMENTATION

Issued to (Last, First Name)		Certification or Provider No.	Date of Birth * _____ / _____ / _____
Course Title			Course Number
Date Conducted			Total Elective Credits **
Session Location			Credits *: _____ *Trauma/Medical: _____ *Other: _____
State	County *	Region *	Certification Level *
Name of Coordinator/Instructor *(Print)*	Signature of Coordinator/Instructor		Date

* Fields marked with an "*" are required for PA providers.

** Fields marked with an "**" are required for NJ providers.

All other fields are mandatory for both states.

Pennsylvania providers must submit a copy of this document directly to their Regional EMS Council for addition to their continuing education records.

New Jersey providers must retain this document as part of their personal recertification records.

EMS-28
JAN 12