# Hudson Valley Regional Emergency Medical Services Council

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www.hvremsco.org


## Application for HVREMAC Credentials Re-Examination

## *To Be Completed By Agency*

**PROVIDER:** _____

First Name Last Name

**PROVIDER ADDRESS:**

Address Line 1

Address Line 2

City State Zip Code

**PROVIDER LEVEL:** ❒ EMT-PARAMEDIC ❒EMT-Critical Care ❒ AEMT

NYS EMT Certification # Expiration Date

**PROVIDER CONTACT INFORMATION:**

Phone Number Mobile Phone Number

**AGENCY:** _____

Agency Name Agency Number

### Agency Representative Must Complete The Following):

❒ The Agency supports the request of the applicant to be credentialed in the Hudson Valley Region as an Advanced Life Support Provider at the level indicated above.

❒ By selecting this box the agency affirms the provider has completed all required remediation prior to sitting for the HVREMAC credentialing exam.

**Name of Agency Representative** **Title**

Contact Phone # Email Address

Signature Date

***In supporting this application/revocation, the Agency acknowledges that it is responsible for adhering to all policies and procedures promulgated by the HVREMSCO and HVREMAC.***

I herby certify that all of the information in this application is true and correct and that the signature above is mine as the Primary Agency Representative. I further understand that offering or providing false information on this document may subject any certification to revocation or other action deemed appropriate by the REMAC.