Hudson Valley Regional Emergency Medical Services Council, Inc.
33 Airport Center Drive ~ Suite 204 Second Floor
New Windsor, NY 12553
Phone: (845) 245-4292
www.hvremsco.org

Credentialing Renewal Application

****DO NOT FAX this FORM****

Last Name _____ **First Name** _____ **Middle Initial** _____

Address Line 1: _____

Address Line 2: _____

City _____ **State** _____ **Zip Code** _____

Contact Information:

Home Phone _____ **Mobile Phone** _____ **Work Phone** _____

E-Mail Address _____

Level of Care: ◯ **Paramedic** ◯ **Critical Care** ◯ **AEMT**

NYS EMT _____ **Expiration Date** _____ **HVREMAC#** _____

Certified EMS Providers

◯ A copy of my NYS DOH certification is included with this submission.

- Or -

◯ I have taken a NYS Certification Exam Prior to my expiration date and will submit a copy of my card once received.

- Or -

◯ I applied for recertification through the NYS CME Recertification Program prior to my expiration date and will submit a copy of my card once received.

**** Paramedic and EMT-Critical Care providers must also submit copies of valid BCLS, ACLS, and PALS (or PEPP) cards ****

I affirm that:

1. I have read and agree to abide by all policies and procedures as promulgated by the Hudson Valley Regional Emergency Medical Advisory Committee (HVREMAC). I understand failure to do so may result in the loss of my regional privileges to provide ALS care.

2. I understand it is my responsibility to advise the HVREMAC of any changes in contact information or agency affiliation(s) and unanswered or unclaimed mail sent via USPS by the HVREMAC still constitutes legal notice.

Applicant Signature _____ **Date** _____

Physician Contact Hour and Medical Control Contact Hour Worksheet

∗∗ Only physician and medical control contact hour education verified by the HVREMSCO Office will be awarded credit ∗∗

Date	Topic	Hours	Category		Date	Topic	Hours	Category	
			◯ PC	◯ MC				◯ PC	◯ MC
			◯ PC	◯ MC				◯ PC	◯ MC
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			◯ PC	◯ MC				◯ PC	◯ MC

Agency Information

Primary Agency

∗∗ Any change of the provider's primary agency requires completion of an Agency Affiliation Form ∗∗

Agency Name **Agency Number**

The Agency supports the request of the applicant to re-credential in the Hudson Valley Region as an Advanced Life Support Provider at the level indicated above and affirms:

1. The ALS provider is currently affiliated as an advanced level pre-hospital care provider for the primary agency.
2. It has ON SITE documentation attesting to the attendance of the provider at the required number of Physician Contact hours and Medical Control hours to renew the provider's Hudson Valley Regional ALS credentials.
3. It acknowledges that all provider attendance records are subject to audit by the Hudson Valley Regional EMS Office, without prior notification, and must be produced upon request of an authorized agent of the Hudson Valley REMAC.

Chief of Operations or Designee Name (PRINT) **Title**

Email Address **Phone Number**

Signature **Date**

THIS FORM MUST BE SUBMITTED 45 DAYS PRIOR TO THE EXPIRATION OF THE PROVIDER'S HVREMAC CREDENTIALS

PRINT **RESET**