



Hudson Valley EMS Council
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(845) 245-4292 www.hvremSCO.org

Broadcast Site
Satellite Site

Name (Please Print)	HV MAC #	REMO MAC #	EMT #	Signature	e-Mail (Please Print)

Course Name: _____

Physician Name: _____

Course Location: _____

Course Length: _____

Medical Control Credit: Yes ____ No ____

REMAC Approval Code: _____

Course Date: _____

Page ____ of ____

I attest to the fact that all personnel listed within this form were present during the listed training session:

Signature of Physician