Hudson Valley Regional
Emergency Medical Services Council
33 Airport Center Drive ~ New Windsor, NY 12553
(845) 245-4292 ~ fax: (845) 245-4181

Medical Control Shadow Program
Patient Profile Form

Provider Name: ____ **MAC #:** __________

Rotation Site: ____ **Date:** _________

Medical Control Representative: ____

Demographic Data:			**PMHX & HPI:**
Age:			
Chief Compliant:			
Male ❒ Female ❒ Pediatric ❒			
Signs & Symptoms:			

Assessment Notes:
Additional Findings:
Treatments Given:

Upon completion of the clinical rotation, a copy of this completed form must be submitted to the agency designated CME Coordinator along with a CME authorization form signed by the Medical Control Representative and should be maintained in the provider's CME file. A minimum of three patient profiles must be completed.