REGIONAL PARAMEDIC PROGRAM
FOR EASTERN ONTARIO

SERVING TOGETHER

Phone: 613-737-7228
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www.rppeo.ca

Return to Clinical Practice Form

INSTRUCTIONS FOR USE:

Stakeholder Service Staff:
Complete parts A and B, click on submit button at the bottom of this form or email to education@rppeo.ca and quality@rppeo.ca.

Continuing Education and Certification Administrative Staff:
Complete parts C and D, then submit the form to the Quality Management Portfolio to complete part E.

Clinical Coordinator
Complete part F, then submit the form to the Continuing Education and Certification Manager.

Manager, Continuing Education and Certification
Complete part G, then file the form.

PART A: CANDIDATE IDENTIFICATION

Name: _____ EHS No.: _____

S.O.P.: ☐ EMA ☐ PCP ☐ ACP

Service: ☐ Cornwall ☐ Lanark ☐ Ottawa
☐ Frontenac ☐ Leeds-Grenville ☐ Prescott-Russell
☐ Hastings-Quinte ☐ Lennox-Addington ☐ Renfrew

PART B: RETURN TO WORK DATE AND CONSTRAINTS

Duration of clinical inactivity: _____ days

If applicable:

1. Expected observation shift date: _____ (yyyy-mm-dd)
2. Expected evaluation shift date: _____ (yyyy-mm-dd)
3. Expected return to regular operations: _____ (yyyy-mm-dd)

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Notes pertaining to GRASP process:

☐ Please note by clicking on the check box, it will be considered equivalent to your signature and you agree to the terms below:
I certify that the above information is correct and true to the best of my knowledge.

Superintendent name (print): _____ Date: _____ (yyyy-mm-dd)

PART C: CURRENT CERTIFICATION STATUS

Current (re)certification status: ☐ Certified ☐ Deactivated ☐ Decertified

Last RSOP held: ☐ EMA-SAED ☐ EMA-SR ☐ PCP ☐ ACP-2 ☐ ACP-3

Last (re)certification date: _____ (yyyy-mm-dd)

PART D: CME Review

Last C1 CME completed: _____

Last C2 CME completed: _____

Last Elective CME completed: _____ (yyyy-mm-dd)

Additional information/comments:

☐ See supporting documents

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PART E: Clinical Practice Review

Review period: ☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months

Patient care variances: _____ minor _____ major _____ critical _____ documentation

Clinical deactivations: ☐ None ☐ 1 ☐ 2 or more

Additional information/comments:

PART F: RETURN TO CLINICAL PRACTICE PLAN

Notes pertaining to CME:

If applicable:

Expected RPPEO PCP/ACP written testing date: _____ (yyyy-mm-dd)*

Expected RPPEO PCP/ACP skill testing date: _____ (yyyy-mm-dd)*

*Please ensure dates are prior to expected evaluation shift and communicate dates with service

☐ (A) MD consulted prior to implementation of the RTCP CME plan

☐ Completed (cannot be checked until all supporting CME paperwork is received by RPPEO staff)

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Clinical Evaluation:

☐ (A)MD consulted prior to implementation of the RTCP Clinical Evaluation plan

☐ Completed (cannot be checked until all supporting CME paperwork is received by RPPEO staff)

☐ Please note by clicking on the check box, it will be considered equivalent to your signature and you agree to the terms below:
I certify that the above statement is true based on the information provided.

Clinical Coordinator name (print): _____ Date: _____ (yyyy-mm-dd)

PART G: REACTIVATION/RECERTIFICATION DECISION

☐ Reactivate/recertify the paramedic

☐ Do not reactivate/recertify the paramedic

☐ Please note by clicking on the check box, it will be considered equivalent to your signature and you agree to the terms below:
I certify that the above statement is true based on the information provided.

CEC Manager name (print): _____ Date: _____ (yyyy-mm-dd)

Submit form