



## 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](mailto:education@rppeo.ca) and [quality@rppeo.ca](mailto: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)



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



**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)



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)