



REGIONAL PARAMEDIC PROGRAM  
FOR EASTERN ONTARIO

**ONTARIO BASE HOSPITAL GROUP  
CROSS-CERTIFICATION REQUEST FORM**

(Current/Most Recent Employment)

**PART A: PARAMEDIC INFORMATION** *To be completed by the paramedic*

First & Last Name:	Last Name:	Former Last Name:
EHS #:	Telephone Number:	
Email Address:	Work Email Address:	
Educational Institution:	Program Title:	
City:	Province:	Year of Graduation:
Would you like to attach an educational certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Base Hospital currently certified at:		
Certification History: <i>Must include ALL Base Hospital(s) previously certified at</i>		Year:
		Year:
<b>Has your ability to practice as a paramedic even been denied, reduced, suspended or revoked by anyone for reasons other than an absence from clinical practice (e.g. parental leave, injury leave etc.)?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain: _____		
Base Hospital/College of Paramedicine/ Other regulatory or delegating authority name: _____		
Date: _____ Certification Level: _____		
<b>Have you ever been the subject of disciplinary proceedings, a decertification process or medical-legal litigation (e.g. negligence or malpractice)?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain: _____		
Base Hospital/College of Paramedicine/ Other regulatory or delegating authority name: _____		
Date: _____ Certification Level: _____		
<b>Is your ability to practice as a paramedic currently being restricted or investigated by a Base Hospital?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain: _____		
Base Hospital/College of Paramedicine/ Other regulatory or delegating authority name: _____		
<b>Have you every voluntarily ceased to practice paramedicine?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain: _____		
Date: _____		
<b>Are you a member of any another health care-providing profession (e.g. PSW, Registered Nurse, etc.)?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain: _____		

**PART B: DECLARATION AND RELEASE OF INFORMATION AUTHORIZATION***To be completed by the paramedic*

In making this Certification Request,

1. I declare that the information I have provided is true and accurate to the best of my knowledge.
2. I acknowledge that falsification of records and misrepresentation of facts are grounds for withholding certification or decertification.
3. I consent to any person or organization disclosing of all information, including personal information, regarding my education, performance, licensure and certification to the Southwest Ontario Regional Base Hospital Program so that the Southwest Ontario Regional Base Hospital Program may validate and evaluate my Certification Request.

I consent to the Southwest Ontario Regional Base Hospital Program disclosing to anyone my certification status (e.g. Consolidation, Certification including level of care and flight or land designation, Deactivation, Administrative Decertification or Clinical Decertification).

In addition, I consent to the Southwest Ontario Regional Base Hospital Program disclosing to any other Base Hospital, College of Paramedicine, or other regulatory or delegating authority the reasons for my status (e.g. Deactivation because of a Patient Care Concern, Clinical Decertification for falsification of medical records, etc.)

I authorize the ongoing release of information to the Southwest Ontario Regional Base Hospital Program from other Base Hospitals regarding my count of patient care contacts for the purposes of maintenance of certification.

I understand that checking this box has the same binding effect as a signature  Date: \_\_\_\_\_

**PART C: CERTIFICATION INFORMATION***To be completed by all current/previous Base Hospital***Current/Most Recent Employment**

Base Hospital:		Employer Name:	
Most current scope of practice:	<input type="checkbox"/> Primary Care Paramedic	Date of Initial Certification:	
	<input type="checkbox"/> Advanced Care Paramedic	Date of Initial Certification:	
	<input type="checkbox"/> Primary Care Flight Paramedic	Date of Initial Certification:	
	<input type="checkbox"/> Advanced Care Flight Paramedic	Date of Initial Certification:	
	<input type="checkbox"/> Critical Care Paramedic	Date of Initial Certification:	
Last Mandatory CME:		Decertification/Departure Date:	
Last ACR record where care was provided:			
Has this paramedic ever been deactivated/decertified by a Medical Director for issues surrounding their Paramedic Certification or had his/her ability to practice paramedicine denied, reduced, suspended or revoked for reasons other than an absence from clinical practice (e.g. parental leave, injury, etc.)?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please complete the section below:			
Date of Deactivation/ Decertification:	Type of Deactivation/ Decertification:	Certification Level:	
Has this Paramedic been the subject of disciplinary proceedings or medical-legal litigation (e.g. negligence or malpractice)?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please explain: _____			

**PART D: CURRENT AUXILIARY MEDICAL DIRECTIVES AND AUXILIARY MEDICATION CERTIFICATION**

*To be completed by previous Base Hospital*

List of directives/medications:	PCP	ACP	List of directives/medications:	PCP	ACP
Continuous Positive Airway Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cricothyrotomy		<input type="checkbox"/>
PCP IV Access and Fluid Admin	<input type="checkbox"/>		Nasotracheal Intubation		<input type="checkbox"/>
Cardiogenic Shock	<input type="checkbox"/>		Procedural Sedation		<input type="checkbox"/>
Manual Defibrillation	<input type="checkbox"/>		Amiodarone		<input type="checkbox"/>
COVID-19	<input type="checkbox"/>	<input type="checkbox"/>	Fentanyl		<input type="checkbox"/>
Special Event (Headache, Minor Abrasion, Minor Allergic Reaction, Musculoskeletal Pain)	<input type="checkbox"/>	<input type="checkbox"/>	Lidocaine		<input type="checkbox"/>
Adult Intraosseous Access		<input type="checkbox"/>	<b>Treat &amp; Discharge Medical Directives</b>	<b>PCP</b>	<b>ACP</b>
<b>Chemical Exposure Medical Directives</b>	<b>PCP</b>	<b>ACP</b>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Symptomatic Riot Agent Exposure	<input type="checkbox"/>	<input type="checkbox"/>	Seizure	<input type="checkbox"/>	<input type="checkbox"/>
Hydrofluoric Acid Exposure	<input type="checkbox"/>	<input type="checkbox"/>	Tachydysrhythmia		<input type="checkbox"/>
Adult Nerve Agent Exposure	<input type="checkbox"/>	<input type="checkbox"/>	<b>Other: (pilots/research projects/novel medical directive)</b>		
Pediatric Nerve Agent Exposure	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>
Cyanide Exposure	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>

**ALS PCS Version:**

**PART E: CONSOLIDATION**

*To be completed by previous Base Hospital*

Is this Paramedic fully certified (i.e. has completed consolidation)?

Comments: \_\_\_\_\_

- Yes
- No

**PART F: OTHER COMMENTS**

*To be completed by previous Base Hospital*

**PART G: BASE HOSPITAL CONFIRMATION**

*To be completed by previous Base Hospital*

Name:	
Title:	
Email:	
Signature:	
Date:	