



PARAMEDIC CERTIFICATION REQUEST FORM

Phone: 613-737-7228

Fax: 613-737-1028

www.rppeo.ca

Instructions for use:

1. Paramedic or paramedic student: Complete parts A, B, C and D, and submit form to your service or college.
2. Paramedic service or college: Complete parts, E, F, and G, and fax (613-737-1028) or email (certification@rppeo.ca) form to the RPPEO.

Part A: Paramedic or Student Information

First Name: _____ **EHS No.:** _____
Last Name: _____ **Home Phone:** _____
No. and Street: _____ **Cell Phone:** _____
City: _____ **Province:** _____ **Postal Code:** _____ **Email:** _____

Part B: Education History

Primary Care Paramedic Program

College Name: _____
City and Province: _____
Phone: _____
Program Title: _____
Year of Graduation: _____

Advanced Care Paramedic Program

College Name: _____
City and Province: _____
Phone: _____
Program Title: _____
Year of Graduation: _____

Part C: Certification History

Have you been certified by one or more Ontario base hospitals to perform controlled acts in the last five years?

- No
 Yes Please list base hospitals: _____

Part D: Release of Information Authorization

I authorize the release of the information provided above to the Regional Paramedic Program for Eastern Ontario, via my employer and/or college. I authorize my employer and/or college to discuss my case with the RPPEO and to retain a copy of this form on file.

Signature: _____

Date: _____



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Part E: Certification Request

Paramedic Service or College:

Scope of Practice: EMA PCP ACP

Requested Certification Session Date:

Form Completion Date:

Part F: Auxiliary Controlled Acts Request

Skill	EMA	PCP	ACP
12-Lead ECG Interpretation		<input type="checkbox"/>	
Central Venous Access Device			<input type="checkbox"/>
Chemical Exposure Medical Directives		<input type="checkbox"/>	<input type="checkbox"/>
Conducted Energy Weapon Probe Removal		<input type="checkbox"/>	<input type="checkbox"/>
Continuous Positive Airway Pressure		<input type="checkbox"/>	<input type="checkbox"/>
Endotracheal Tube Introducer			<input type="checkbox"/>
Peripheral Intravenous Therapy		<input type="checkbox"/>	
Special Events Medical Directives		<input type="checkbox"/>	<input type="checkbox"/>
Supraglottic Airway Insertion		<input type="checkbox"/>	<input type="checkbox"/>
Symptom Relief	<input type="checkbox"/>		

Part G: Attestation of Certification Eligibility Under O. Reg 257/00

I attest that the information contained herein is factual, that this individual meets all of the requirements for certification to perform controlled acts as outlined in Ontario Regulation 257/00, and that my service holds copies of the following documents pertaining to this individual:

Document	EMA	PCP	ACP	Date Issued
CPR Certificate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
PCP Program Diploma		<input type="checkbox"/>	<input type="checkbox"/>	_____
AEMCA		<input type="checkbox"/>	<input type="checkbox"/>	_____
ACP Program Diploma			<input type="checkbox"/>	_____
Ontario ACP Certificate			<input type="checkbox"/>	_____

Name:

Signature:

Date:

RPPEO USE ONLY

Request No.:

Certification Letter Issued On:

Received On:

Sent to Data Management On:

CPC Coordinator Notified On:

Entered On: