REGIONAL PARAMEDIC PROGRAM
FOR EASTERN ONTARIO

SERVING TOGETHER

Return to Clinical Practice Form

Phone: 613-737-7228
Fax: 613-737-1028
www.rppeo.ca

INSTRUCTIONS FOR USE:

Paramedic:
Complete parts A, B and C, then submit the form to the RPPEO via email to education@rppeo.ca and quality@rppeo.ca.

Continuing Education and Certification Administrative Staff:
Ensure parts A, B and C are completed, then submit the form to the Clinical Coordinator.

Clinical Coordinator
Review parts A, B and C, then forward form to Stakeholder Service to initiate return to clinical practice.

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: SELF-ASSESSMENT

Have you visited the RPPEO's website and reviewed the:

- Medical directives for your scope of practice? ☐ Yes ☐ No
- New/revised policies posted during your clinical inactivity? ☐ Yes ☐ No
- Medical advisories posted during your clinical inactivity? ☐ Yes ☐ No

Have you received a copy of the 2011 ALS PCS pocket book? ☐ Yes ☐ No

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As a way to facilitate you return to work, please list specific skills or knowledge you would like to review:

What clinical and/or educational support can the RPPEO provide before you return to clinical practice?

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PART C: SPECIAL REQUIREMENTS

If applicable, please list any learning accommodations you may have:

_____

_____

_____

If applicable, please list any work restrictions you may have:

_____

_____

_____

☐ Please note by clicking on the check box, it will be considered equivalent to your signature and you agree to the terms below:

I authorize the release of the information provided above to the Regional Paramedic Program for Eastern Ontario (RPPEO) 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.

Paramedic Name (print) : _____ Date: _____(yyyy-mm-dd)

FOR OFFICE USE ONLY

☐ Based on the information provided above, I agree to commence the Return to work program.

Clinical Coordinator name: _____ Date of form review: _____ (yyyy-mm-dd)

Submit form