



## **Instructions for Use: Initial Certification Form**

**Purpose:** This form is designed to facilitate the initial certification process for paramedics/paramedic students and service operators/academic institutes. Please follow the steps below to ensure the form is completed accurately and promptly.

### **Step 1: Service Operators/Academic Institutes, please complete sections A, B & C**

Section A: Certification Request

Section B: Certification Eligibility

Section C: Attestation of Certification Eligibility

Please forward this form to your certification candidate for completion. Once received, ensure that all information is accurate and complete. Verify the authenticity of educational and training documents, and keep a copy of the completed form along with all supporting documents for your records.

Please forward the original completed form to the Northwest Region Prehospital Care Program at  
[TBRHSC.NWRPCPAdmin@tbh.net](mailto:TBRHSC.NWRPCPAdmin@tbh.net)

### **Step 2: Paramedic/Paramedic student, please complete sections D, E, F & G**

Section D: Personal Information:

Section E: Paramedic Education History

Section F: Paramedic Employment & Certification History (if applicable)

Section G: Authorization for Release of Information

Please submit the completed form and all required attachments to your designated service operator or academic institution for submission

### **Additional Notes:**

Ensure all sections of the form are completed legibly and accurately.

Incomplete or incorrect forms may delay the certification process.

If you have any questions or require assistance, please contact the NWRPCP directly.

Thank you for your cooperation in ensuring a smooth and efficient initial certification process.



SECTION A: CERTIFICATION REQUEST		SERVICE OPERATOR/ACADEMIC INSTITUTE	
Name of Ambulance Service Operator or Academic Institute:			
Name of Paramedic or Paramedic Student:			
Requested Level of Certification:	<input type="checkbox"/> Primary Care – Professional	<input type="checkbox"/> Advanced Care – Professional	
	<input type="checkbox"/> Primary Care - Academic	<input type="checkbox"/> Advanced Care – Academic	
Offer of Employment Date/Start Date:			

SECTION B: CERTIFICATION ELIGIBILITY UNDER Reg. 257/00		SERVICE OPERATOR/ACADEMIC INSTITUTE	
<b>Documents – Check all that apply</b>			
Valid CPR Certificate:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
PCP Graduate:	<input type="checkbox"/> Yes	<input type="checkbox"/> n/a	
MOHLTC A-EMCA Certificate:	<input type="checkbox"/> Yes	<input type="checkbox"/> Pending	
ACP Graduate:	<input type="checkbox"/> Yes	<input type="checkbox"/> n/a	
MOHLTC ACP Certificate:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

SECTION C: ATTESTATION OF CERTIFICATION ELIGIBILITY		SERVICE OPERATOR/ACADEMIC INSTITUTE	
<b>Please sign this form and submit to Northwest Region Prehospital Care Program</b>			
I attest that the information contained herein is factual, that this individual meets all the requirements for certification to perform controlled acts as outlined in Ontario Regulation 257/00, or in accordance with NWRPCP policy CERT 1000, and that my Service or Academic Institute holds copies of the listed documents pertaining to this individual.			
Name:			
Title/Position:			
Email:			
<input type="checkbox"/> I acknowledge that by checking this box, it carries the same legal weight and binding effect as signing my name.			Date:
<b>Please forward this form to your certification candidate for completion. Once received, ensure all information is accurate and complete and submit to Northwest Region Prehospital Care Program at:</b>			
<a href="mailto:TBRHSC.NWRPCPAdmin@tbh.net">TBRHSC.NWRPCPAdmin@tbh.net</a>			

SECTION D: PARAMEDIC OR PARAMEDIC STUDENT INFORMATION		PARAMEDIC/PARAMEDIC STUDENT	
First Name:		EHS (if applicable):	
Last Name:		Phone Number:	
Address:		City:	
Province:		Postal Code:	
Email:			

SECTION E: PARAMEDIC EDUCATION HISTORY		PARAMEDIC/PARAMEDIC STUDENT	
PRIMARY CARE PARAMEDIC PROGRAM		ADVANCED CARE PARAMEDIC PROGRAM	
Academic Institute:		Academic Institute:	
City and Province:		City and Province:	
Program Title		Program Title	
Year of Graduation (or expected):		Year of Graduation (or expected):	



SECTION F: PARAMEDIC EMPLOYMENT & CERTIFICATION HISTORY			PARAMEDIC APPLICANT ONLY
<b>Please include all certification history within the last 10 years</b>			
<b>MOST RECENT EMPLOYMENT</b>			
Ambulance Service Operator:			
Base Hospital/Certifying Body:			
Level of Certification:	<input type="checkbox"/> Primary Care	<input type="checkbox"/> Advanced Care	<input type="checkbox"/> Critical Care
Date Employed:		Last Day Worked:	
<b>ADDITIONAL EMPLOYMENT</b>			
Ambulance Service Operator:			
Base Hospital/Certifying Body:			
Level of Certification:	<input type="checkbox"/> Primary Care	<input type="checkbox"/> Advanced Care	<input type="checkbox"/> Critical Care
Date Employed:		Last Day Worked:	
<b>ADDITIONAL EMPLOYMENT</b>			
Ambulance Service Operator:			
Base Hospital/Certifying Body:			
Level of Certification:	<input type="checkbox"/> Primary Care	<input type="checkbox"/> Advanced Care	<input type="checkbox"/> Critical Care
Date Employed:		Last Day Worked:	
<b>Has your ability to practice ever been denied, reduced, suspended or revoked by a Base Hospital/Certifying body for reasons other than an absence from clinical practice (e.g. maternity/parental leave, injury, etc.), OR, have you ever been the subject of disciplinary proceedings, a decertification process or medical-legal litigation? If yes, please explain:</b>			<input type="checkbox"/> YES  <input type="checkbox"/> NO

SECTION G: AUTHORIZATION FOR RELEASE OF INFORMATION		PARAMEDIC/PARAMEDIC STUDENT
<b>Please sign this form and submit it to your Ambulance Service Operator or Academic Institute</b>		
I authorize the release of the information provided on this form to the Northwest Region Prehospital Care Program, via my Ambulance Service Operator and/or Academic Institute and/or Base Hospital. I authorize my Ambulance Service Operator and/or Academic Institute and/or Base Hospital to discuss my case with respect to all my files with the Northwest Region Prehospital Care Program, and to retain a copy of this form on file.		
Paramedic or Paramedic Student Name:		Date:
<input type="checkbox"/> I acknowledge that by checking this box, it carries the same legal weight and binding effect as signing my name.		
<b>Please complete, sign and submit this form to your Ambulance Service Operator or Academic Institute for submission</b>		