Thunder Bay Regional Health Sciences Centre
Northwest Region Prehospital Care Program

290 Munro St., Suite 2400, Thunder Bay, ON P7A 7T1
Phone: (807)684-7950
E-mail: TBRHSC.NWRPCPAdmin@tbh.net

INITIAL CERTIFICATION REQUEST FORM

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 Prehopsital Care Program at 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.

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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:	☐ Primary Care – Professional	☐ Advanced Care – Professional
	☐ Primary Care - Academic	☐ Advanced Care – Academic
Offer of Employment Date/Start Date:		

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

SECTION C: ATTESTATION OF CERTIFICATION ELIGIBILITY		SERVICE OPERATOR/ACADEMIC INSTITUTE
Please sign this form and submit to Northwest Region Prehospital Care Program		
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:		
☐ I acknowledge that by checking this box, it carries the same legal weight and binding effect as signing my name.		Date:

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:
TBRHSC.NWRPCPAdmin@tbh.net

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):	

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SECTION F: PARAMEDIC EMPLOYMENT & CERTIFICATION HISTORY			**PARAMEDIC APPLICANT ONLY**
Please include all certification history within the last 10 years			
MOST RECENT EMPLOYMENT			
Ambulance Service Operator:			
Base Hospital/Certifying Body:			
Level of Certification:	☐ Primary Care	☐ Advanced Care	☐ Critical Care
Date Employed:		Last Day Worked:	
ADDITIONAL EMPLOYMENT			
Ambulance Service Operator:			
Base Hospital/Certifying Body:			
Level of Certification:	☐ Primary Care	☐ Advanced Care	☐ Critical Care
Date Employed:		Last Day Worked:	
ADDITIONAL EMPLOYMENT			
Ambulance Service Operator:			
Base Hospital/Certifying Body:			
Level of Certification:	☐ Primary Care	☐ Advanced Care	☐ Critical Care
Date Employed:		Last Day Worked:	

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:	☐ YES ☐ NO

SECTION G: AUTHORIZATION FOR RELEASE OF INFORMATION			**PARAMEDIC/PARAMEDIC STUDENT**
Please sign this form and submit it to your Ambulance Service Operator or Academic Institute			
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:	
☐ I acknowledge that by checking this box, it carries the same legal weight and binding effect as signing my name.			
Please complete, sign and submit this form to your Ambulance Service Operator or Academic Institute for submission			