Thunder Bay Regional Health Sciences Centre
Northwest Region Prehospital Care Program

**Northwest Region Prehospital Care Program**
290 Munro St., Suite 2400, Thunder Bay, ON P7A 7T1
**Phone:** (807)684-7950 **Fax:** (807)683-3211
**E-mail:** basehospital@tbh.net

# Initial Certification

**SECTION A** *(to be completed by the Paramedic & Employer Requesting Certification)*

## CONTACT INFORMATION

**Certification Level Requested** ☐ PCP ☐ACP

| | |
|---|---|
| **Name:** | **EHS#:** *(if applicable)* |
| **Phone #:** | **E-Mail:** |
| **Address:** | |

## EMPLOYMENT STATUS

| | | | | |
|---|---|---|---|---|
| ☐ ***NAOTEMS*** | ☐ ***NWEMS*** | ☐ ***RRDPS*** | ☐ ***SNEMS - City*** | ☐ ***SNEMS - District*** |

## PARAMEDIC EDUCATION

***(copy of all documentation required to proceed through the certification process)***

| | | |
|---|---|---|
| **College Name:** | ☐ PCP ☐ACP | Graduating Year: |
| **AEMCA** ☐ Yes ☐ No | Certificate Year: | |
| Letter of Expectation to Graduate (must include skills trained in) ***OR*** College Diploma | Date issued: | |

**SECTION B** *(to be completed by Paramedic if applicable)*

## BASE HOSPITAL CERTIFICATION HISTORY

Name of Base Hospital where certification was held:

| | |
|---|---|
| Date of last Certification: | Level: ☐ PCP ☐ PCP Academic ☐ ACP ☐ ACP Academic |

| | |
|---|---|
| **Has your ability to practice as a paramedic ever been denied, reduced, suspended or revoked by Service Operator/Program Medical Director for reasons other than an absence from clinical practice (e.g. Maternity/Parental leave, injury etc.)? If yes, please explain:**<br>_____<br>**Base Hospital/College of Paramedicine/Other regulatory or delegating authority Name:**_____<br>**Date:** _____ **Certification Level:** _____ | ☐ **Yes**<br>☐ **No** |
| **Have you ever been the subject of disciplinary proceedings, a decertification process or medical-legal litigation (e.g. negligence or malpractice)? If yes, please explain:**<br>_____<br>**Base Hospital/College of Paramedicine/Other regulatory or delegating authority name:** _____<br>**Date:** _____ **Certification Level:** _____ | ☐ **Yes**<br>☐ **No** |
| **Is your ability to practice as a paramedic currently being restricted or investigated by a Base Hospital? If yes, please explain:**<br>_____<br>**Base Hospital/College of Paramedicine/Other regulatory or delegating authority Name:**_____<br>**Date:** _____ **Certification Level:** _____ | ☐ **Yes**<br>☐ **No** |

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| **Section C: CURRENT AUXILIARY MEDICAL DIRECTIVES AND AUXILIARY MEDICATION CERTIFICATION** *To be completed by previous Base Hospital (if applicable)* | | | | | |
|---|---|---|---|---|---|
| **List of directives/medications:** | **PCP** | **ACP** | **List of directives/medications:** | **PCP** | **ACP** |
| Continuous Positive Airway Pressure | ☐ | ☐ | Cricothyrotomy | | ☐ |
| PCP IV Access and Fluid Administration | ☐ | | Nasotracheal Intubation | | ☐ |
| Cardiogenic Shock | ☐ | | Procedural Sedation | | ☐ |
| Manual Defibrillation | ☐ | | Amiodarone | | ☐ |
| COVID-19 | ☐ | ☐ | Fentanyl | | ☐ |
| Special Event (Headache, Minor Abrasion, Minor Allergic Reaction, Musculoskeletal Pain) | ☐ | ☐ | Lidocaine | | ☐ |
| Adult Intraosseous Access | | ☐ | **Treat & Discharge Medical Directives** | **PCP** | **ACP** |
| **Chemical Exposure Medical Directives** | **PCP** | **ACP** | Hypoglycemia | ☐ | ☐ |
| Symptomatic Riot Agent Exposure | ☐ | ☐ | Seizure | ☐ | ☐ |
| Hydrofluoric Acid Exposure | ☐ | ☐ | Tachydysrhythmia | ☐ | ☐ |
| Adult Nerve Agent Exposure | ☐ | ☐ | **Other: (pilots/research projects/novel medical directive)** | | |
| Pediatric Nerve Agent Exposure | ☐ | ☐ | Other: | ☐ | ☐ |
| Cyanide Exposure | ☐ | ☐ | Other: | ☐ | ☐ |
| | | | **ALS PCS Version:** | | |

**Section D: 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 Northwest Region Prehospital Care Program (NWRPCP) so that the Northwest Region Prehospital Care Program may validate and evaluate my Certification Request.

I consent to the Northwest Region Prehospital Care 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 Northwest Region Prehospital Care 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 Northwest Region Prehospital Care 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: _____

**Section E: EMPLOYER SUPPORTING CERTIFICATION**

The above paramedic meets all qualifications for employment under the Ontario Regulation 257/00 under the Ambulance Act. ☐ Yes ☐ No

| **EMS Operator Name:** | | **Date:** |
|---|---|---|

Please download and save this form then submit by email at TBRHSC.NWRPCPAdmin@thb.net