

# **INSTRUCTIONS FOR REPORT OF EMERGENCY MEDICAL RESPONDER (EMR) CONTINUING EDUCATION**

Part of State Form 55869 (R3 / 4-25)  
DEPARTMENT OF HOMELAND SECURITY

- I. To renew a certification, applicants for original certification as a first responder shall meet the following requirements:
  - A. Be a minimum of fourteen (14) years of age
  - B. Have successfully completed the following:
    1. A commission-approved first responder course
    2. State written and practical skills examinations as approved by the commission
- II. Certification as a first responder will be valid for a period of two (2) years.
- III. To renew a certification, a first responder shall submit a report of continuing education every two (2) years that meets or exceeds the minimum requirements to take and report twenty (20) hours of continuing education according to the following:
  - A. Participate in a minimum of sixteen (16) hours of any combination of lectures, critiques, skills proficiency examinations, or audit and review that review subject matter presented in the Indiana first responder curriculum.
  - B. Participate in a minimum of four (4) hours in defibrillation and airway management as presented in the Indiana first responder curriculum.



# REPORT OF EMERGENCY MEDICAL RESPONDER (EMR) CONTINUING EDUCATION

State Form 55869 (R3 / 4-25)

DEPARTMENT OF HOMELAND SECURITY

## PERSONAL INFORMATION

Printed name of EMR ( <i>last, first, middle initial</i> )		Public safety identification number (PSID)
Home address ( <i>number and street, city, state, and ZIP code</i> )		
Home telephone number (      )	E-mail address	

## VIOLATION STATEMENT

Since your last renewal, have you been charged or convicted of anything other than a minor traffic violation? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, have you reported it to the IDHS Compliance Officer? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, on what date did you report it? ( <i>month, day, year</i> )
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## SIGNATURE OF EMR

I, the undersigned EMR, hereby affirm, under the penalty for perjury, that all statements on this continuing education report are true and correct, including copies of cards, certificates, and other required documents for verification. I understand that false statements or documents may be sufficient cause for revocation by the Indiana Department of Homeland Security and the Emergency Medical Services Commission. I also understand that the Indiana Department of Homeland Security and the Emergency Medical Services Commission may conduct an audit of the recertification activities listed at any time.

Signature of EMR	Date ( <i>month, day, year</i> )
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## CURRENT AFFILIATIONS - AMBULANCE PROVIDER ORGANIZATIONS

Name of provider	Provider certification number	Telephone number (      )
Street address ( <i>number and street, city, state, and ZIP code</i> )		
Signature of Chief Executive Officer / Training Officer		Date ( <i>month, day, year</i> )
Name of provider	Provider certification number	Telephone number (      )
Street address ( <i>number and street, city, state, and ZIP code</i> )		
Signature of Chief Executive Officer / Training Officer		Date ( <i>month, day, year</i> )

SECTION I: ADDITIONAL HOURS OF CONTINUING EDUCATION
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1. Participate in a minimum of sixteen (16) hours of any combination of lectures, critiques, skills proficiency examination, or audit and review that reviews subject matter presented in the Indiana first emergency medical responder curriculum.
2. Participate in a minimum of four (4) hours in defibrillation and airway management as presented in the Indiana responder curriculum.

- | DATE<br>(month, day, year) | NUMBER<br>OF HOURS | TOPIC | TRAINING OFFICER<br>SIGNATURE | TRAINING OFFICER<br>NAME AND PSID<br>NUMBER |
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