Peoria Area EMS System
304 E Illinois Street – Room 114
Peoria, Illinois 61637
(309) 655-2113
www.paems.org

Peoria Area EMS System Recertification Checklist

☐ **EMR**	☐ **EMT-B**	☐ **EMT-I /AEMT**	☐ **Paramedic**	☐ **PHRN**
☐ **EMD**	☐ **Lead Instructor**			

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Address: _____ **Apt. #:** _____

City: _____ **State:** IL_____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____ **SS#:** _____

Email Address: _____ **Driver's License #:** _____

IDPH License Number: _____ **Expiration Date:** _____

Agency(s) Affiliation: _____ **NinthBrain Account?** ☐ **Yes** ☐ **No**

All Provider Levels:

- ☐ Copy of current IDPH license
- ☐ Copy of driver's license
- ☐ IDPH Renewal Notice/Child Support/Personal History Statement
- ☐ Copy of current CPR card - May be AHA Healthcare Provider or ARC Professional Rescuer
- ☐ Continuing education hours: (Paramedics 100 hours, EMT-Is / AEMTs 80 hours, EMT-Bs 60 hours, First Responders 24 hours & must follow PAEMS System guidelines on the number of hours allowed per subject matter and be verified by the PAEMS System Manager)
- ☐ Payment of IDPH renewal license fee or submission of Volunteer License Fee Waiver Application

Additional EMT-Intermediate, Paramedic & PHRN Certifications

- ☐ Copy of current Advanced Cardiac Life Support (ACLS) certification – ACLS certification must be from the American Heart Association
- ☐ Copy of current Pediatric Advanced Life Support (PALS) or Pediatric Education for Pre-Hospital Professionals (PEPP) certification - PALS certification must be from the American Heart Association
- ☐ Copy of current Trauma Criteria Education (ITLS) or (PHTLS) certification

I understand that as an EMS Provider in the Peoria Area EMS System I must comply with all Policies, Procedures, and Protocols as set forth by the EMS Medical Director and Medical Advisory Board. I understand that violation of any policy, procedure, and/or protocol is noncompliance with the expected Standard of Care and such action may result in immediate corrective action, including System suspension.

Authorized Agency Representative Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____