

# Emergency Medical Services

## Prereview Questionnaire

### 1. Provide information on the last assessment of EMS, including assessor and date.

The last comprehensive assessment was done by the Texas Department of Health and provided to the 75<sup>th</sup> Texas Legislature in 1996. Patti Patterson, M.D. was the Commissioner of Health. A hard-bound copy of the assessment, "*Report To The 75<sup>th</sup> Texas Legislature 1996*", will be available on-site for review.

#### **(a) Describe the EMS system, including the number and competencies (that is, ALS or BLS) of ground transporting agencies, non-transporting agencies, and air medical resources.**

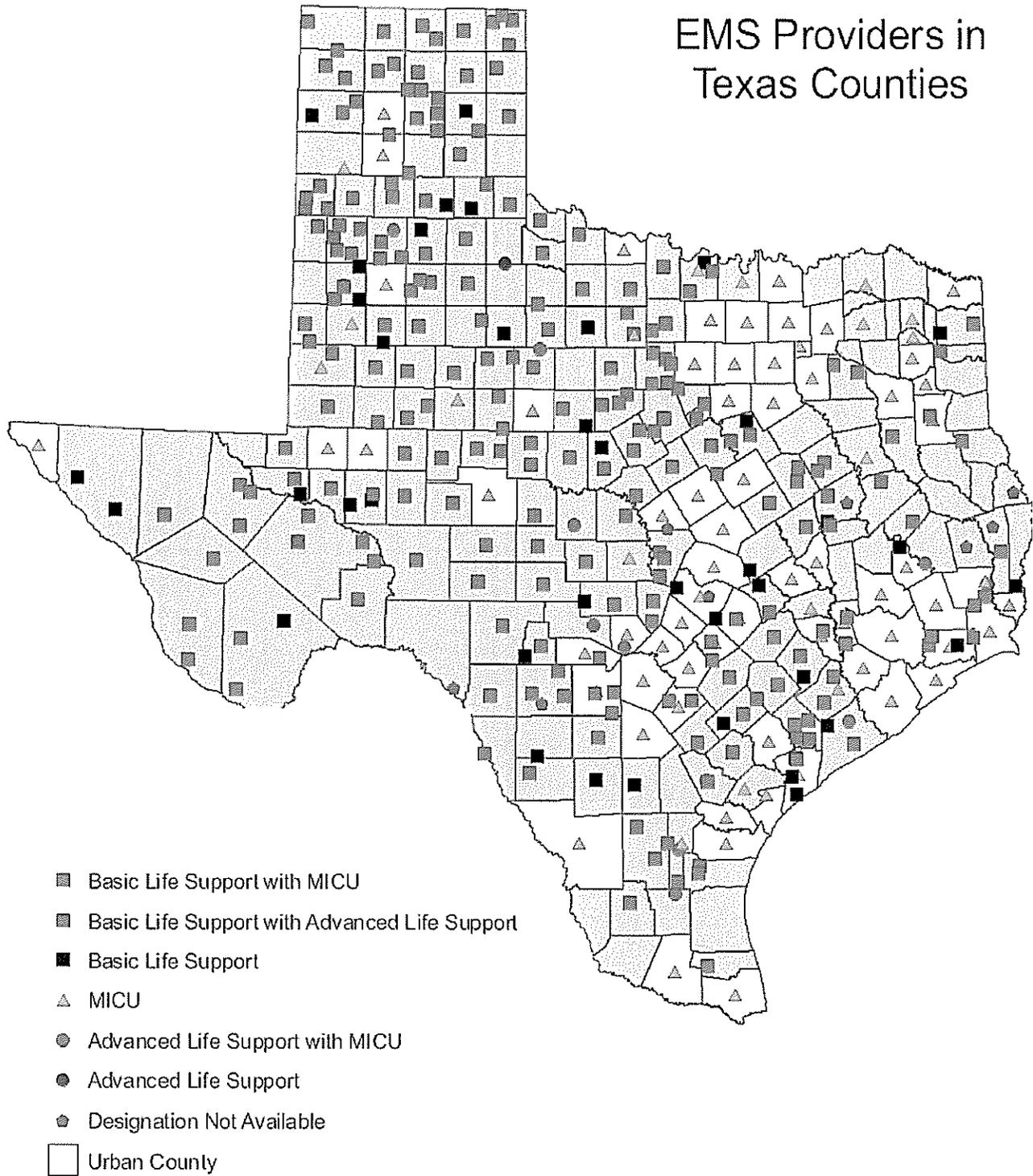
In 1943, ambulance permitting legislation (48<sup>th</sup> Legislature), Vernon's Civil Statutes, Article 4590-b, required ambulance attendants to complete 8 hours of unspecified first-aid training and for each vehicle to be equipped with a first aid kit. The contents of the first aid kit were not specified. Applications for a permit to operate an ambulance were to be made to "any public health officer of any of the political sub-divisions of the state where said applicant's principal place of business is located", and the State Board of Health subsequently issued a two-year permit. Prior to 1996, most applicants' principal place of business were funeral homes that sent hearses to pick up survivors and transport them to the hospital.

Many changes have taken place since Texas developed an EMS voluntary registry in 1970. Some of these changes include: EMS investigations; Local Projects and ECA Training Grants; and certification/licensure of 5 levels of EMS personnel and multiple levels of providers/firms and education programs. There are more than 55,000 certified EMS personnel across the state, 1,145 firms, and 158 education programs. See attachment (1a.0) *Texas EMS History Timeline*.

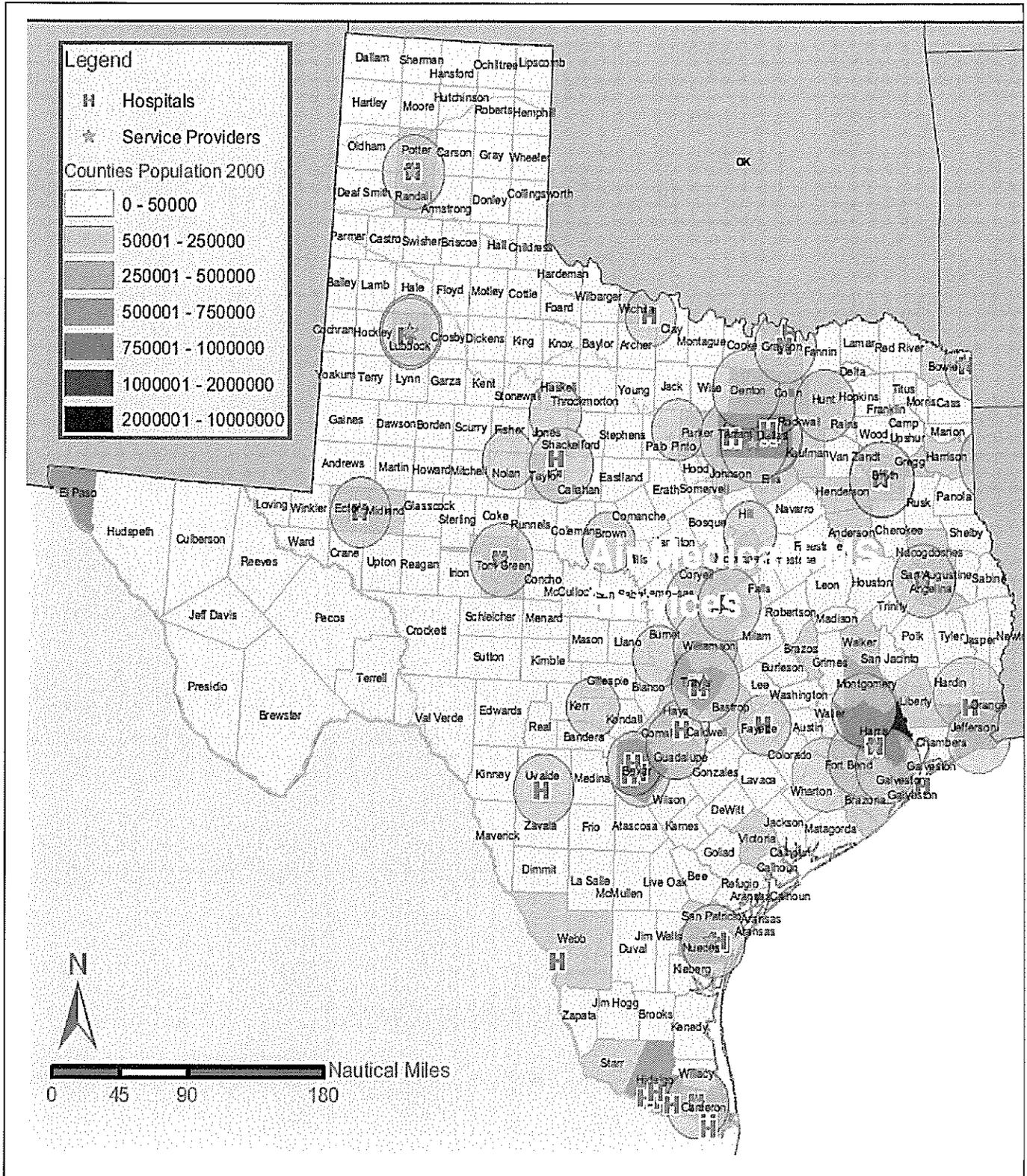
Texas EMS is not recognized as an essential service. However some government organizations provide 911 ambulance service to their citizens through a municipal-based service or a private provider. Others allow volunteers for privately-owned ambulance companies to provide this service. Many ambulance providers are transfer companies and do not provide emergency 911 service. The 1132 ground ambulance agencies in Texas have the following certification levels. Some of our EMS providers maintain a dual certification levels, for example BLS with MICU capabilities. This allows them to staff at a higher level when there are advanced life support medics available.

Ground MICU = 199; ALS = 37; BLS = 295; multiple levels of Certification 601; Air Ambulance MICU 20. Total Firms Licensed = 1132.

## EMS Providers in Texas Counties



There is a total of 4853 licensed EMS vehicles. BLS 1016; BLS/ALS 246; ALS /MICU 37; BLS/MICU 2357; Ground MICU 1024; Rotor Wing 78; Fixed Wing 38 and 57 specialty lessened vehicles.



**(b) How are these resources allocated throughout the region to serve the population?**

Companies can establish EMS businesses across the state as long as they meet the minimum requirements established by statute and rule. There is no formula to decide where or how these resources are allocated throughout the state.

**(c) Describe the availability of enhanced 911 and wireless E-911 access in your region.**

Funding was appropriated to CSEC in fiscal years 2008-2009 to implement Wireless Phase II capability at 303 public safety answering points (PSAPs) in the state's 24 regional planning commissions (RPC).

The CSEC/RPC program has met and exceeded the FY 2008-2009 target established by the Legislature for this key performance measure. A PSAP is Phase II capable when it has the equipment and mapping required to receive and display the x/y coordinates of a 9-1-1 caller's location. 350 PSAPs are Phase II capable. A Phase II capable PSAP is authorized by the Federal Communications Commission (FCC) to place a request for Phase II enhanced 9-1-1 service with each wireless carrier in its region. 100% of PSAPs have requested Phase II service from all carriers. A wireless carrier has deployed Phase II service when it has enabled and tested the network, database, and location determining technology that sends a 9-1-1 caller's x/y coordinates to a PSAP. The FCC allows wireless carriers 6 to 12 months to deploy Phase II service upon receipt of a valid request from a PSAP. 89% of PSAPs had deployed Phase II service with all of the carriers in the region, as of July 1, 2009.

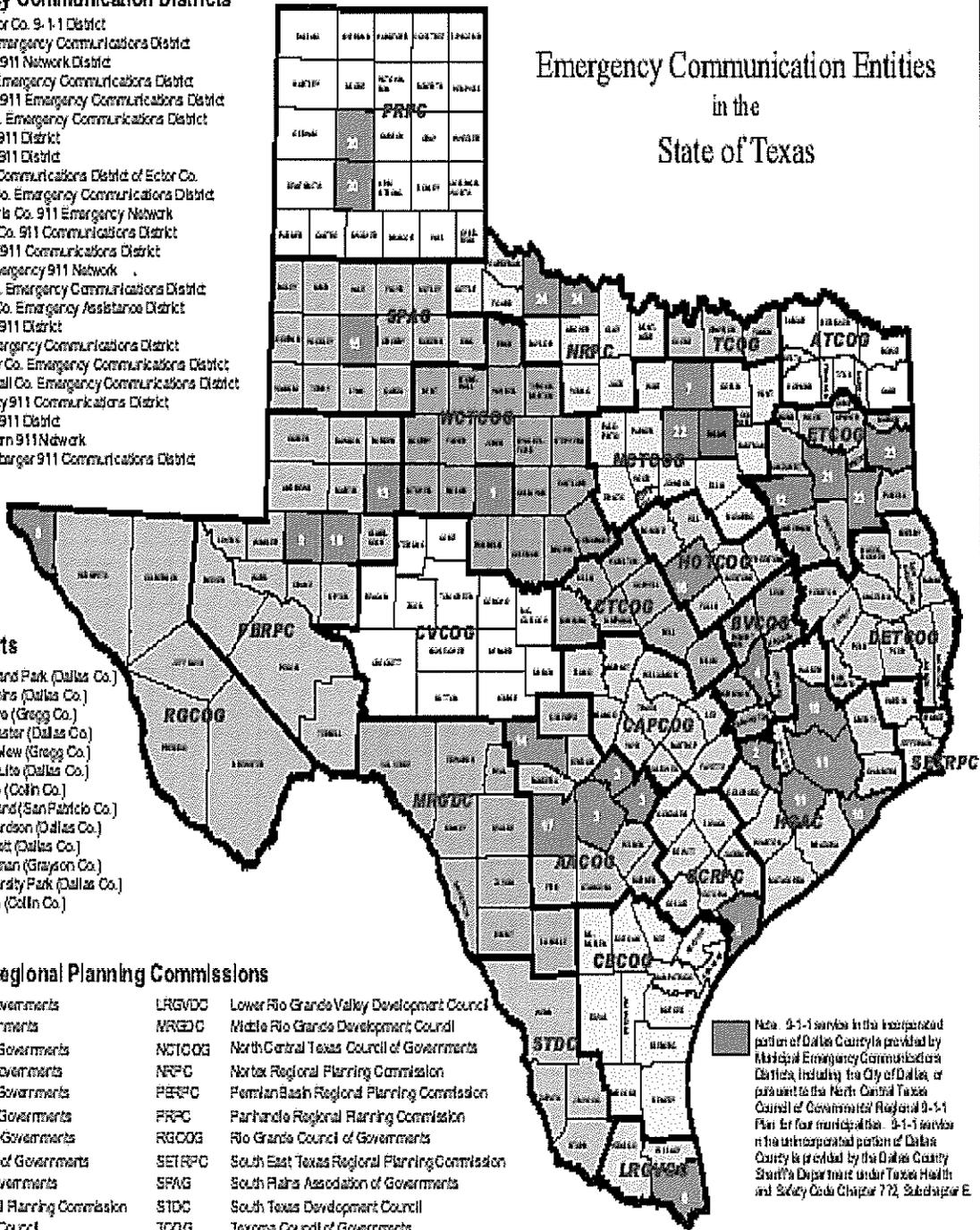


**Commission on  
State Emergency  
Communications**

**Emergency Communication Districts**

- 1 Abilene/Taylor Co. 9-1-1 District
- 2 Austin Co. Emergency Communications District
- 3 Bexar Metro 911 Network District
- 4 Brazos Co. Emergency Communications District
- 5 Calhoun Co. 911 Emergency Communications District
- 6 Cameron Co. Emergency Communications District
- 7 Danco/Area 911 District
- 8 El Paso Co. 911 District
- 9 Emergency Communications District of Ector Co.
- 10 Galveston Co. Emergency Communications District
- 11 Greater Harris Co. 911 Emergency Network
- 12 Henderson Co. 911 Communications District
- 13 Howard Co. 911 Communications District
- 14 Kerr Co. Emergency 911 Network
- 15 Lubbock Co. Emergency Communications District
- 16 McCombs Co. Emergency Assistance District
- 17 Medina Co. District
- 18 Midland Emergency Communications District
- 19 Montgomery Co. Emergency Communications District
- 20 Potter-Randall Co. Emergency Communications District
- 21 Smith County 911 Communications District
- 22 Tarrant Co. 911 District
- 23 Texas Eastern 911 Network
- 24 Wichita/Wilbarger 911 Communications District

**Emergency Communication Entities  
in the  
State of Texas**



**Municipal Emergency  
Communication Districts**

- |                             |                              |
|-----------------------------|------------------------------|
| Addicks (Dallas Co.)        | Highland Park (Dallas Co.)   |
| Ansonia Plaza (Ansonia Co.) | Hutchins (Dallas Co.)        |
| Cedar Hill (Dallas Co.)     | Kilgore (Gregg Co.)          |
| Coppell (Dallas Co.)        | Lancaster (Dallas Co.)       |
| Corpus Christi (Nueces Co.) | Longview (Gregg Co.)         |
| Dallas (Dallas Co.)         | Mesquite (Dallas Co.)        |
| De Soto (Dallas Co.)        | Plano (Collin Co.)           |
| Denton (Grayson Co.)        | Portland (San Patricio Co.)  |
| Duncanville (Dallas Co.)    | Richardson (Dallas Co.)      |
| Ennis (Ellis Co.)           | Rowlett (Dallas Co.)         |
| Farmers Branch (Dallas Co.) | Sherman (Grayson Co.)        |
| Garland (Dallas Co.)        | University Park (Dallas Co.) |
| Glenn Heights (Dallas Co.)  | Wylie (Collin Co.)           |

**Regional Planning Commissions**

- |        |                                              |        |                                               |
|--------|----------------------------------------------|--------|-----------------------------------------------|
| AACOG  | Arno Area Council of Governments             | LRGVDC | Lower Rio Grande Valley Development Council   |
| ATCOG  | Ark-Tex Council of Governments               | MREDC  | Middle Rio Grande Development Council         |
| BVCOG  | Brazos Valley Council of Governments         | NTCOG  | North Central Texas Council of Governments    |
| CAPCOG | Capital Area Council of Governments          | NRPC   | Northwest Regional Planning Commission        |
| CBCOG  | Coastal Bend Council of Governments          | PERPC  | Pemian Basin Regional Planning Commission     |
| CTCOG  | Central Texas Council of Governments         | FRPC   | Farther Regional Planning Commission          |
| CVCOG  | Concho Valley Council of Governments         | RGCOG  | Rio Grande Council of Governments             |
| DETCOG | Deep East Texas Council of Governments       | SETRPC | South East Texas Regional Planning Commission |
| ETCOG  | East Texas Council of Governments            | SPAG   | South Plains Association of Governments       |
| GCRCPC | Golden Crescent Regional Planning Commission | STDC   | South Texas Development Council               |
| HGAC   | Houston-Galveston Area Council               | TCOG   | Texoma Council of Governments                 |
| HTCOG  | Heart of Texas Council of Governments        | WCTCOG | West Central Texas Council of Governments     |

Note: 9-1-1 service in the incorporated portion of Dallas County is provided by Municipal Emergency Communications Districts, including the City of Dallas, or pursuant to the North Central Texas Council of Governments' Regional 9-1-1 Plan for four municipalities. 9-1-1 service in the unincorporated portion of Dallas County is provided by the Dallas County Sheriff's Department under Texas Health and Safety Code Chapter 772, Subchapter E.

Source: Fall 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 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**(d) Identify any specialty pediatric transporting agencies and aero-medical resources.**

There are currently nine (9) EMS firms licensed as pediatric specialty units. Their fleets consist of 24 ground pediatric specialty ambulances, four (4) fixed wing airplanes, and 2 rotor wings helicopters

**(e) Describe the availability of pediatric equipment on all ground transporting units.**

The EMS provider shall submit a list, approved by the medical director and fully supportive of and consistent with the protocols, of all medical equipment, supplies, medical devices, parenteral solutions and pharmaceuticals to be carried. The list shall specify the quantities of each item to be carried and shall specify the sizes and types of each item necessary to provide appropriate care for all age ranges appropriate to the needs of their patients. The quantities listed shall be appropriate to the provider's call volume, transport times and restocking capabilities.

The following items shall be present on each EMS in-service vehicle and on, or immediately available for, each response-ready vehicle in quantities, sizes and types as specified in the equipment list as required in the sizes and types of each item necessary to provide appropriate care for all age ranges appropriate to the needs of their patients.

(1) Basic Life Support:

- (A) oral-pharyngeal airways;
- (B) portable and vehicle mounted suction;
- (C) bag valve mask units, oxygen capable;
- (D) portable and vehicle mounted oxygen;
- (E) oxygen delivery devices;
- (F) dressing and bandaging materials;
- (G) rigid cervical immobilization devices;
- (H) spinal immobilization devices;
- (I) extremity splints;
- (J) equipment to meet special patient needs;
- (K) equipment for determining and monitoring patient vital signs, condition or response to treatment;
- (L) pharmaceuticals, as required by medical director protocols;
- (M) An External Cardiac Defibrillator appropriate to the staffing level;
- (N) A patient-transport device capable of being secured to the vehicle; and
- (O) An epinephrine auto injector or similar device capable of treating anaphylaxis.

(2) Advanced Life Support:

- (A) all required BLS equipment;
- (B) advanced airway equipment;
- (C) IV equipment and supplies; and
- (D) pharmaceuticals as required by medical director protocols.

(3) MICU:

- (A) all required BLS and ALS equipment;
- (B) cardiac monitor/defibrillator; and
- (C) pharmaceuticals as required by medical director protocols.

(4) BLS with ALS Capability:

- (A) all required BLS equipment, even when in service or response ready at the ALS level; and
- (B) all required ALS equipment, when in service or response ready at the ALS level.

(5) BLS with MICU Capability:

- (A) all required BLS equipment, even when in service or response ready at the MICU level; and
- (B) all required MICU equipment, when in service or response ready at the either the MICU level.

(6) ALS with MICU Capability:

- (A) all required ALS equipment, even when in service or response ready at the MICU level; and
- (B) all MICU equipment, when in service or response ready at the MICU level.

(7) In addition to medical supplies and equipment:

- (A) a complete and current copy of written protocols approved by the medical director; with a current and complete equipment, supply, and medication list.

The Pediatric committee of the Governor's EMS and Trauma Advisory Council developed an EMS ambulance supply list and recommended providers transporting children use this list.

**Governor's EMS and Trauma Advisory Council  
Pediatric Committee  
BLS and ALS Recommended EMS Ambulance Supply List**

| Basic Life Support (BLS)                                                                              |   |
|-------------------------------------------------------------------------------------------------------|---|
| Oropharyngeal airways – oral airways sizes 00-5<br>infant<br>child<br>adult                           | E |
| Nasopharyngeal airways (include training for authorized EMS<br>personnel)<br>infant<br>child<br>adult | E |

|                                                                                                            |   |
|------------------------------------------------------------------------------------------------------------|---|
| Self-inflating bag-valve mask devices (oxygen reservoir without pop-off valve)<br>infant<br>child<br>adult | E |
| Masks for bag-valve-mask device<br>Neonatal (for delivery of premature infant)<br>infant<br>child<br>adult | E |
| Oxygen masks<br>infant<br>child<br>adult                                                                   | E |
| Non-rebreather masks<br>pediatric<br>adult                                                                 | E |
| Nasal cannulas<br>infant<br>child<br>adult                                                                 | D |
| Portable and vehicle mounted oxygen                                                                        | E |
| Portable and vehicle mounted suction (portable suction to include regulator)                               | E |
| Suction catheters (include pediatric tonsil-tip and sizes 6F-14F)                                          | E |
| Stethoscopes<br>infant<br>Pediatric<br>adult                                                               | E |
| Bulb syringe                                                                                               | E |
| Blood pressure cuffs<br>infant<br>child<br>adult                                                           | E |
| Thermometers                                                                                               | E |
| Dressing and bandaging materials                                                                           | E |

**2. Describe the procedures for online and off –line medical direction, including procedures for the pediatric population.**

**On-Line Medical Direction**

- (a) The EMS medical director shall assign the pre-hospital provider under his or her direction to a specific on-line communication resource by a predetermined policy.
- (b) Specific local protocols shall define the circumstances under which on-line medical direction is required.
- (c) A physician providing or delegating on-line medical direction ("on-line physician") shall be appropriately trained in the use of pre-hospital protocols.
- (d) A physician providing or delegating on-line medical direction shall have personal expertise in the emergency care of ill and injured patients.
- (e) A physician providing or delegating on-line medical direction for particular patients assumes responsibility for the appropriateness of pre-hospital care provided under his or her direction by EMS personnel.

**Off-line Medical Director**

(a) An off-line medical director shall be:

- (1) a physician licensed to practice in Texas and shall be registered as an EMS medical director with the Texas Department of State Health Services;
- (2) familiar with the design and operation of EMS systems;
- (3) experienced in pre-hospital emergency care and emergency management of ill and injured patients;
- (4) actively involved in:
  - (A) the training and/or continuing education of EMS personnel, under his or her direct supervision, at their respective levels of certification;
  - (B) the medical audit, review, and critique of the performance of EMS personnel under his or her direct supervision;
  - (C) the administrative and legislative environments affecting regional and/or state pre-hospital EMS organizations;
- (5) knowledgeable about local multi-casualty plans;
- (6) familiar with dispatch and communications operations of pre-hospital emergency units; and
- (7) knowledgeable about laws and regulations affecting local, regional, and state EMS operations.

(b) The off-line medical director shall be required to:

- (1) approve the level of pre-hospital care which may be rendered locally by each of the EMS personnel employed by and/or volunteering with the EMS under the medical director's supervision, regardless of the level of state certification or licensure, before the certificant or licensee is permitted to provide such care to the public;

- (2) establish and monitor compliance with field performance guidelines for EMS personnel;
- (3) establish and monitor compliance with training guidelines which meet or exceed the minimum standards set forth in the Texas Department of State Health Services EMS certification regulations;
- (4) develop, implement, and revise protocols and/or standing delegation orders, if appropriate, governing pre-hospital care and medical aspects of patient triage, transport, transfer, dispatch, extrication, rescue, and radio-telephone-telemetry communication by the EMS;
- (5) direct an effective system audit and quality assurance program;
- (6) determine standards and objectives for all medically related aspects of operation of the EMS including the inspection, evaluation, and approval of the system's performance specifications;
- (7) function as the primary liaison between the EMS administration and the local medical community, ascertaining and being responsive to the needs of each;
- (8) develop a letter or agreement or contract between the medical director(s) and the EMS administration outlining the specific responsibilities and authority of each. The agreement should describe the process or procedure by which a medical director may withdraw responsibility for EMS personnel for noncompliance with the Emergency Medical Services Act, the Health and Safety Code, Chapter 773, the rules adopted in this chapter, and/or accepted medical standards;
- (9) take or recommend appropriate remedial or corrective measures for EMS personnel, in conjunction with local EMS administration, which may include, but are not limited to, counseling, retraining, testing, probation, and/or field preceptorship;
- (10) suspend a certified EMS individual from medical care duties for due cause pending review and evaluation;
- (11) establish the circumstances under which a patient might not be transported;
- (12) establish the circumstances under which a patient may be transported against his or her will in accordance with state law, including approval of appropriate procedures, forms, and a review process;
- (13) establish criteria for selection of a patient's destination;
- (14) develop and implement a comprehensive mechanism for management of patient care incidents, including patient complaints, allegations of substandard care, and deviations from established protocols and patient care standards

**(a) Describe how EMS and trauma medical direction and oversight are coordinated and integrated.**

Each provider is required to have a medical director with a protocol for therapy for that provider. Trauma care directions are established by the Regional Advisory Councils (RAC's) and the medical director for each provider works with the RAC's to establish triage and transportation guidelines.

**3. Describe the pre-hospital workforce competencies in trauma:**

The levels of EMS certification recognized by the department are: Emergency Care Attendant (First Responder), Emergency Medical Technician-Basic, Emergency Medical Technician-Intermediate; Paramedic and Licensed Paramedic.

**(a) Initial training and certification/licensure requirements**

**(1) Emergency Care Attendant (ECA)**

- (A) The minimum curriculum shall include all content required by the current national EMS First Responder educational standards and competencies as defined by the United States Department of Transportation (DOT).
- (B) In addition to the minimum curriculum in subparagraph (A) of this paragraph, the curriculum shall include the following subjects:
  - (i) recognition and identification of hazardous materials as defined by the Federal Emergency Management Agency curriculum, "Recognizing and Identifying Hazardous Materials";
  - (ii) airway/ventilation adjuncts; to include use of the bag-valve mask, oxygen administration and oral suctioning;
  - (iii) measurement of baseline vital signs to include pulse, respiration and blood pressure by palpation and auscultation;
  - (iv) spinal motion restriction, to include sizing and application of cervical collars and short/long spinal motion restriction devices to supine, seated, and standing patients;
  - (v) patient assessment;
  - (vi) bandaging, splinting, and traction splinting;
  - (vii) cardiac arrest management, including use of the semi-automatic external defibrillator;
  - (viii) equipment used to lift and move patients;
  - (ix) communications and documentation; and
  - (x) ambulance operations, to include emergency vehicle laws.
- (C) The course shall include a minimum of 40 clock hours of classroom and laboratory instruction in the approved curriculum.

**(2) Emergency Medical Technician-Basic (EMT-B)**

- (A) The minimum curriculum shall include all content required by the current national EMT-B educational standards and competencies as defined by DOT.
- (B) The course shall include a minimum of 140 clock hours of classroom, laboratory, clinical, and field instruction which shall include supervised experiences in the emergency department, with a licensed EMS provider and in other settings as needed to develop the competencies defined in the minimum curriculum.

**(3) Emergency Medical Technician-Intermediate (EMT-I)**

- (A) The minimum curriculum shall include all content required by the portions of the current national paramedic education standards and competencies as defined by DOT which address the following areas:
  - (i) roles and responsibilities of the paramedic;

- (ii) well being of the paramedic;
- (iii) illness and injury prevention;
- (iv) medical/legal issues;
- (v) ethics;
- (vi) general principles of pathophysiology;
- (vii) pharmacology;
- (viii) venous access and medication administration;
- (ix) therapeutic communications;
- (x) life span development;
- (xi) patient assessment;
- (xii) airway management and ventilation, including endotracheal intubation; and
- (xiii) trauma.

- (B) The course shall include a minimum of 160 clock hours of classroom, laboratory, clinical, and field instruction which shall include supervised experiences in the emergency department with a licensed EMS provider, and in other settings as needed to develop the competencies defined in the minimum curriculum.
- (C) Certification as an EMT-Basic shall be required prior to beginning field and clinical rotations in an EMT-I course.

(4) Emergency Medical Technician-Paramedic (EMT-P).

- (A) The minimum curriculum shall include all content required by the current national paramedic education standards and competencies as defined by DOT.
- (B) The course shall include a minimum of 624 clock hours of classroom, laboratory, clinical and field instruction which shall include supervised experiences in the emergency department with a licensed EMS provider and in other settings as needed to develop the competencies defined in the minimum curriculum.
- (C) Certification as an EMT-Basic shall be required prior to beginning field and clinical rotations in an EMT-P course.

**(b) Continuing education and recertification/ re-licensure requirements**

Upon submission of a completed application for recertification, the applicant shall commit to, and recertify through one of the options described in paragraphs (1) - (5) of this subsection.

(1) Option 1--Written Examination Recertification Process.

The applicant shall pass the National Registry (NR) cognitive assessment exam. An overall score of 70 is considered to be passing.

**NR Cognitive Examination**

The NREMT Paramedic cognitive exam is a computer adaptive test (CAT). The number of items a candidate can expect on the Paramedic exam will range from 80 to 150. The exam will cover the entire spectrum of EMS care including: Airway and Breathing, Cardiology, Trauma, Medical, Obstetrics **and Pediatrics**, and EMS

Operations. In order to pass the exam, you must meet a standard level of competency. The passing standard is defined by the ability to provide safe and effective entry level emergency medical care.

If the applicant fails the examination for recertification, the applicant may attempt two retests of the examination after:

- (i) submitting a retest application for each attempt at any eligible level; and
- (ii) submitting a non-refundable retest fee of \$30 for each attempt.

An applicant who does not pass the third attempt at the National Registry assessment examination:

- shall successfully complete a Formal Recertification Course and
- shall submit a course completion certificate of the Formal recertification course, reflecting that the course was completed after the 2nd retest failure; and
- shall pass the National Registry assessment
- shall not qualify for more than a total of six attempts at the exam, in any combination of levels attempted.

The certification status of an applicant who does not successfully complete the examination recertification process shall expire on the date of the current certificate. The applicant will have until 90 days after expiration date of the current certificate to submit the application, pay the renewal fee of 1-1/2 times the amount described in subsection (a)(4) of this section and successfully complete the examination recertification process. If applicable, the retest process, including appropriate retest applications and fees, may continue during the 90-day period.

Successful completion of the late recertification process must be accomplished within one year of expiration.

A candidate whose certificate has been expired for one year or more may not renew the certificate.

- (2) Option 2--Continuing Education Recertification Process. The certificant shall attest to accrual of department approved EMS continuing education as specified in §157.38 of this title (relating to Continuing Education).

| CONTENT AREAS                 | ECA | EMT-B | EMT-I | EMT-P |
|-------------------------------|-----|-------|-------|-------|
| PREPARATORY                   | 3   | 6     | 9     | 12    |
| AIRWAY MANAGEMENT/VENTILATION | 3   | 6     | 9     | 12    |
| PATIENT ASSESSMENT            | 2   | 4     | 6     | 8     |

|                                                |    |    |     |     |
|------------------------------------------------|----|----|-----|-----|
| TRAUMA                                         | 3  | 6  | 9   | 12  |
| MEDICAL                                        | 9  | 18 | 27  | 36  |
| SPECIAL CONSIDERATIONS                         | 3  | 6  | 9   | 12  |
| CLINICALLY RELATED OPERATIONS                  | 1  | 2  | 3   | 4   |
| PEDIATRIC                                      | 3  | 6  | 9   | 12  |
| MINIMUM UNITS IN CONTENT AREAS                 | 27 | 54 | 81  | 108 |
| ADDITIONAL UNITS IN ANY APPROVED CATEGORY      | 9  | 18 | 27  | 36  |
| TOTAL REQUIRED FOR RECERTIFICATION ELIGIBILITY | 36 | 72 | 108 | 144 |

- (3) Option 3--National Registry Recertification Process. The applicant shall attest to and hold current National Registry certification at the time of applying for recertification.

The EMS person has to take the NR exam every two years which includes pediatric content in the spectrum of questions or they can recertify with the NR using approved continuing education courses. Here are the pediatric CE requirements (every 2 years) to meet this option.

- (4) Option 4--Formal Course Recertification Process. The applicant shall attest to successful completion of a department approved recertification course.
- (A) The recertification course shall be a formal structured interactive training course as approved by the department and conducted within the four-year certification period.
- (B) The minimum contact hours required for recertification courses are:

| RECERTIFICATION COURSE |     |       |       |       |
|------------------------|-----|-------|-------|-------|
| CONTENT AREAS          | ECA | EMT-B | EMT-I | EMT-P |
| PREPARATORY            | 3   | 6     | 9     | 12    |
| AIRWAY MGMT /          | 3   | 6     | 9     | 12    |

|                               |    |    |    |    |
|-------------------------------|----|----|----|----|
| VENTILATION                   |    |    |    |    |
| PATIENT ASSESSMENT            | 2  | 4  | 6  | 8  |
| TRAUMA                        | 3  | 6  | 9  | 12 |
| MEDICAL                       | 9  | 18 | 27 | 36 |
| SPECIAL CONSIDERATIONS        | 3  | 6  | 9  | 12 |
| CLINICALLY RELATED OPERATIONS | 1  | 2  | 3  | 4  |
| TOTAL MINIMUM CONTACT HOURS   | 24 | 48 | 72 | 96 |

- (5) Option 5--CCMP Recertification Process. (Not Available) An applicant affiliated with an EMS provider that has a department-approved Comprehensive Clinical Management Program (CCMP) may be recertified if:
- (A) the applicant is currently credentialed in the provider's CCMP;
  - (B) the applicant has been enrolled in the provider's CCMP for at least six continuous months; and
  - (C) the applicant submits to the department a signed written statement by the CCMP's medical director, attesting to the applicant's successful participation in and completion of the provider's CCMP.

**(b) Pediatric trauma training requirements for recertification**  
(see b)