

Adirondack-Appalachian Regional EMS Council

[Here Insert Agency Name]

2017 Collaborative Protocol Rollout ALS Attestation

Collaborative Topics

- Dr. Dailey video overview
- End of Life
- Ketamine
- Patella Reduction
- Calcium Chloride
- Pre-existing Vascular Devices
- Transport Ventilators
- RSI Checklist (optional)

Simulation Video

- Introduction
- Double Sequential Defibrillation
- Surgical Cricothyrotomy- Bougie Assisted (optional)
- OB Field delivery
- Neonatal Resuscitation
- Informal Debrief of Neonatal Resuscitation
- Complications of Delivery and Normal Delivery
- Avulsed Tooth
- Eye Irrigation/ Morgan Lens
- Perfect CPR for Apple Watch (optional)
- Massive Bleeding (with hemostatic wound packing and clot removal)
- Critical Patient Management with RSI
- Formal Debrief of Critical Patient Management Scenario

Podcasts

- New York State Collaborative Protocols Review Part I
- New York State Collaborative Protocols Review Part II

Self-study of Protocols

- Provider acknowledges that the above education does not cover every aspect of these protocols and self-study is necessary to assure familiarity with the protocol document.

Attestation of Completion

I hereby attest that I have completed Self-Study Program for the 2017 New York State EMS Collaborative Protocol Rollout. I have viewed the PowerPoints, watched the videos, listened to the podcasts and reviewed the protocols to assure familiarity. I understand that I am responsible for complying with protocol contents and applicable/appropriate treatment of patients.

Agency Member

Name (please print): _____

EMT Number _____ TEK Number _____

Signature: _____ Date: _____

Agency Name: _____

Agency Training Officer

I hereby confirm that the individual named above has completed the 2017 New York State EMS Collaborative Protocol Rollout Self-study.

Training Officer: _____

Signature: _____ Date: _____

Medical Director

I hereby confirm that the individual named above has completed the 2017 New York State EMS Collaborative Protocol Rollout Self-study.

Medical Director Name: _____

Signature: _____ Date: _____