

## EMS License Renewal Request

Name (as written on license): \_\_\_\_\_

License Held: \_\_\_\_\_ License Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Agency: \_\_\_\_\_

Category	EMR	ECRN	EMD	LI	BLS	ILS	ALS
Airway, including skills lab	2	0	0	4	4	8	10
Breathing, Patient Assessment	3	0	0	6	6	8	8
Circulation, Trauma, Shock/Resuscitation, Pathophysiology	8	0	0	12	18	24	32
Disability, Medical, Behavioral, OB, Infant, Children	6	0	0	12	14	18	18
Environment, Preparations/Operations, Special Populations, Pharmacology	5	0	0	6	10	14	16
<b>Subtotal:</b>	<b>24</b>	<b>0</b>	<b>0</b>	<b>40</b>	<b>52</b>	<b>72</b>	<b>84</b>
Open Topic	0	32	48	0	8	8	16
<b>Total:</b>	<b>24</b>	<b>32</b>	<b>48</b>	<b>40</b>	<b>60</b>	<b>80</b>	<b>100</b>

### Other Documentation Required

- **All Levels**
  - CPR for Healthcare Provider
- **ILS/ALS/ECRN**
  - ACLS
  - PALS, PEPP, or ENPC
  - PHTLS, TECC, TCCC, ITLS, TNCC, or TNS
- **Lead Instructor**
  - Course Evaluations

### EMS Office

- Renewal Received in EMS Office Date: \_\_\_\_\_ By: \_\_\_\_\_
- Renewal Reviewed and Approved Date: \_\_\_\_\_ By: \_\_\_\_\_
- Issues Affecting Renewal: \_\_\_\_\_

## Pain Scales

### Pediatric Pain Scale:

#### Wong-Baker FACES® Pain Rating Scale



**0**

**No  
Hurt**



**2**

**Hurts  
Little Bit**



**4**

**Hurts  
Little More**



**6**

**Hurts  
Even More**



**8**

**Hurts  
Whole Lot**



**10**

**Hurts  
Worst**

### Dementia Pain Scale:

**TABLE 2**

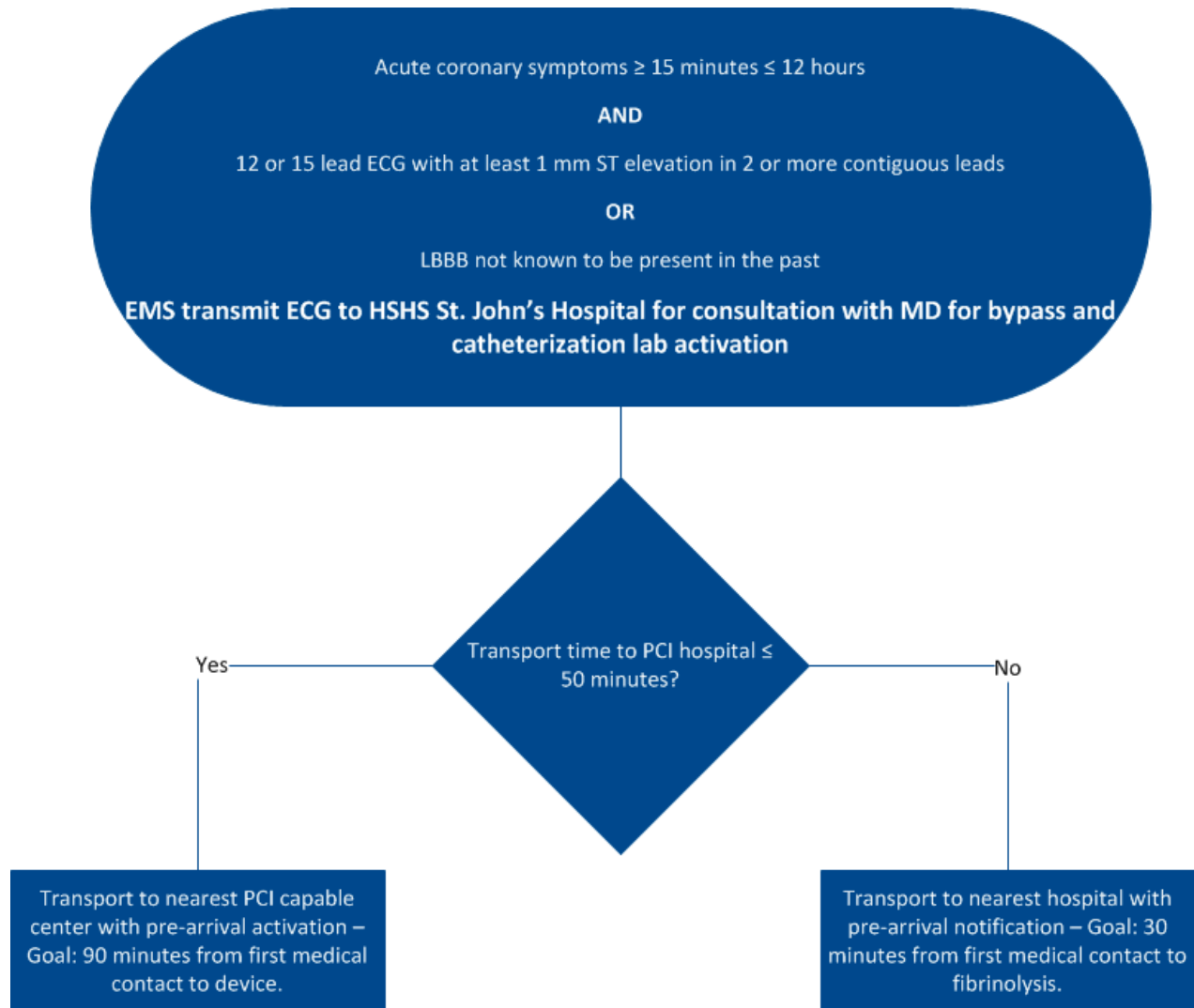
**PAIN ASSESSMENT IN ADVANCED DEMENTIA (PAINAD) SCALE**

Items	Score = 0	Score = 1	Score = 2	Score
Breathing (independent of vocalization)	Normal	<ul style="list-style-type: none"> <li>Occasional labored breathing</li> <li>Short period of hyperventilation</li> </ul>	<ul style="list-style-type: none"> <li>Noisy labored breathing</li> <li>Long period of hyperventilation</li> <li>Cheyne-Stokes respirations</li> </ul>	
Negative vocalization	None	<ul style="list-style-type: none"> <li>Occasional moan or groan</li> <li>Low level of speech with a negative or disapproving quality</li> </ul>	<ul style="list-style-type: none"> <li>Repeated troubled calling out</li> <li>Loud moaning or groaning</li> <li>Crying</li> </ul>	
Facial expression	Smiling or inexpressive	<ul style="list-style-type: none"> <li>Sad</li> <li>Frightened</li> <li>Frown</li> </ul>	<ul style="list-style-type: none"> <li>Facial grimacing</li> </ul>	
Body language	Relaxed	<ul style="list-style-type: none"> <li>Tense</li> <li>Distressed pacing</li> <li>Fidgeting</li> </ul>	<ul style="list-style-type: none"> <li>Rigid</li> <li>Fists clenched</li> <li>Knees pulled up</li> <li>Pulling or pushing away</li> <li>Striking out</li> </ul>	
Consolability	No need to console	<ul style="list-style-type: none"> <li>Distracted or reassured by voice or touch</li> </ul>	<ul style="list-style-type: none"> <li>Unable to console, distract, or reassure</li> </ul>	
Total				

Note. Total scores range from 0 to 10 (based on a scale of 0 to 2 for each of five items), with a higher score indicating more behaviors indicating pain (0 = no observable pain to 10 = highest observable pain).

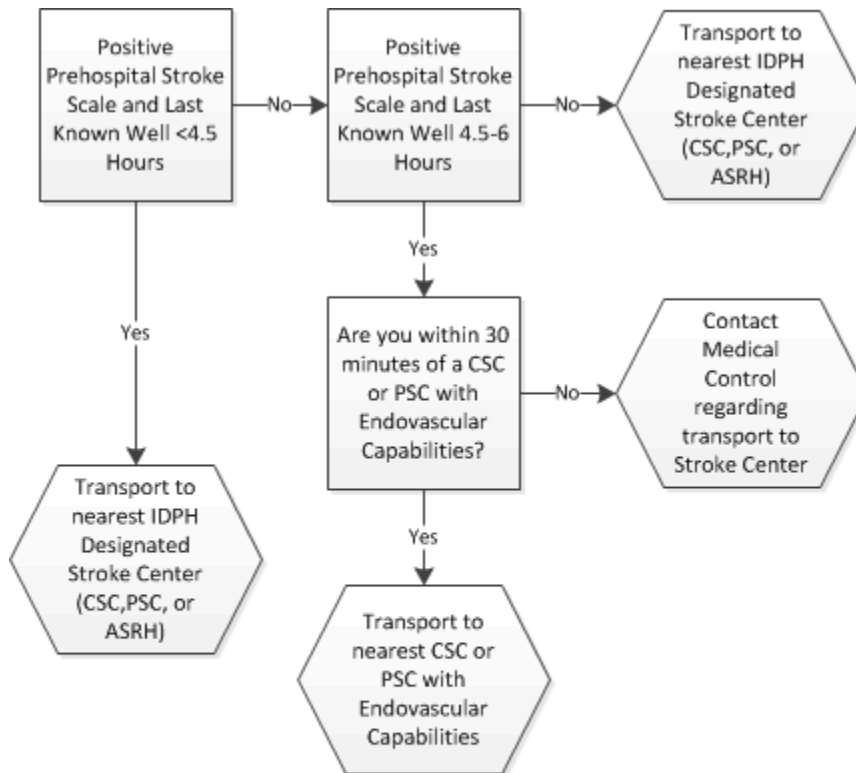
Adapted from Warden, V., Hurley, A.C., & Volicer, L. (2003). Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) scale. *Journal of the American Medical Directors Association*, 4, 9-15.

## STEMI Destination Determination



This bypass applies to specific agencies with system approval. The hospital bypass is ultimately up to the paramedic's discretion after ECG review and physician consultation. Patients who are not hemodynamically stable or suspected to become hemodynamically unstable should be transported to the nearest hospital.

## Region 3 Stroke Destination Determination



IDPH Designated Stroke Centers  
 CSC- Comprehensive Stroke Center  
 PSC- Primary Stroke Center  
 ASRH- Acute Stroke Ready Hospital

If patient is hemodynamically unstable or EMS suspects deterioration of condition **REGARDLESS** of hospital capabilities, transport to closest appropriate hospital.

## Emergency Childbirth Record

Presentation (head or feet): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Time of Birth: \_\_\_\_\_

Nuchal Cord: **Yes** **No** Number of times: \_\_\_\_\_

Time Membranes Ruptured: \_\_\_\_\_

Appearance of Amniotic Fluid: \_\_\_\_\_

APGAR Score:

	0	1	2	1 Minute Score	5 Minute Score
Appearance	Body and Extremities Cyanotic	Acrocyanosis	Pink		
Pulse Rate	Absent	< 100 bpm	>100 bpm		
Grimace (Irritability)	No Response	Minimal Response	Prompt Response		
Activity	Limp	Flexed Arms and Legs	Active		
Respiration	Absent	Slow and Irregular	Strong Cry		
Total Score:					

Time Placenta Delivered: **Intact** **Not Intact** \_\_\_\_\_

Number of Vessels in Cord: \_\_\_\_\_

Infant Resuscitation Interventions: \_\_\_\_\_

Remarks: \_\_\_\_\_

Provider Name (Print): \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Driver Name (Print): \_\_\_\_\_

Driver Signature: \_\_\_\_\_

## Complaint/Unusual Occurrence Report

Report Date: \_\_\_\_\_ Incident Date: \_\_\_\_\_ Person Reporting Complaint: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Follow Up Phone Number: \_\_\_\_\_

Incident Narrative:

Complaint Investigation Notes:

Action Taken: \_\_\_\_\_ Letter to: \_\_\_\_\_

Closing Notes:

## School Bus Incident Log

All individuals on the bus age 18 and older should initial in the indicated space adjacent to their name when uninjured. Parent/legal guardian should initial in the indicated space adjacent to their child's name when uninjured. Initials indicate agreement that no injury has been suffered and no transportation is required to the hospital.

<b>Date:</b>	<b>Location:</b>	<b>District Name:</b>	<b>Bus Number:</b>
<b>Incident Number</b>	<b>Total Patients:</b>	<b># Transported:</b>	<b># Not Transported</b>
<b>Adult Name</b>	<b>Function</b>	<b>Address &amp; Telephone</b>	<b>Initials</b>
<b>Child Name</b>	<b>Age</b>	<b>Address &amp; Telephone</b>	<b>Initials</b>

## School Bus Incident Log

Child Name	Age	Address & Telephone	Initials

**Release to the custody of school official, parent/legal guardian, or self if ≥ 18 years old.**

\_\_\_\_\_  
Name of EMS Provider

\_\_\_\_\_  
Name of School Official

\_\_\_\_\_  
Signature                      Date

\_\_\_\_\_  
Signature                      Date



## Notice of EMS Response to a Minor

**Date:** [Click here to enter a date.](#)

**From:** (Chief or President of Agency)

(Provider Agency)

(Address)

(Phone Number)

**Child's Name:** \_\_\_\_\_

Members of our EMS agency were called to evaluate your son/daughter/ward today as a result of a bus collision/incident.

After responding to the above incident, we evaluated the child. Based on our assessment and statements made by the child, it was determined that he or she did not require emergency care and/or transportation to an emergency department at that time.

Whereas your child is a minor, it is our duty to inform you of this incident so that an informed decision can be made as to whether follow-up evaluation with a physician is desired.

The child was released to a designated school representative who accepted further responsibility for him or her.

**If you wish additional information, please contact our agency at the above phone number.**

\*Note – fillable form available online at [www.samicems.org](http://www.samicems.org)