



**SC DHEC Division of EMS & Trauma  
State In-Service Training Re-certification Form for  
Emergency Medical Technician**

SC State Certification Number	
SC	
SC State Expiration Date	

SSN (Last 4 #s)

National Registry Certification Number	
National Registry Cert. Exp. Date	

Last Name

First Name

E-Mail Address

Date of Birth (mm/dd/yyyy)

Mailing Address

City, State, Zip Code

Home Phone Number (Including Area Code)

Cell Phone Number (Including Area Code)

**In-Service Training (IST) 2011 Option**

**Section IA & 1B: Refresher Requirement (Must satisfy all refresher requirements every two years)**

Basic Refresher Requirement						
(1A) 1st two-year period			Topics	(1B) 2nd two-year period		
Date	Method	Hours		Hours	Method	Date
		1	Preparatory	1		
		2	Airway	2		
		2	OB, Infants, Children	2		
		3	Patient Assessment	3		
		4	Medical / Behavioral	4		
		4	Trauma	4		
		8	Elective	8		
		24	Total	24		

If a formal Basic Refresher course was completed, please attach a copy of the course completion certificate for each two-year period.

Section 1A & 1B:	A maximum of <b>10 hours</b> can be applied from Distributive Education toward refresher requirements and must be CECBEMS or DHEC approved.
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**Section III A & B: Verification of Skill Competence (Must satisfy every two years)**

Basic Skill Competence				
(3A) 1st two-year period		Skill	(3B) 2nd two-year period	
Date	Method		Method	Date
		<b>Patient Assessment/Management</b>		
		<i>Medical</i>		
		<i>Trauma</i>		
		<b>Ventilatory Management Skills/Knowledge</b>		
		<i>Simple Adjuncts</i>		
		<i>Supplemental Oxygen Delivery</i>		
		<i>Bag-Valve-Mask</i>		
		<i>One-Rescuer</i>		
		<i>Two-Rescuer</i>		
		<b>Cardiac Arrest Management / AED</b>		
		<b>Hemorrhage Control &amp; Splinting Procedures</b>		
		<b>Spinal Immobilization</b>		
		<i>Seated &amp; Supine Patients</i>		
		<b>OB/Gynecologic Skills/Knowledge</b>		
		<b>Other Related Skills/Knowledge</b>		
		<i>Radio Communications</i>		
		<i>Report Writing &amp; Documentation</i>		

As the Medical Control Physician for this EMT, I do hereby affix my signature attesting to continued competence in all skills out-lined above.

\_\_\_\_\_  
Signature of Medical Control Physician (**Must be original signature**) + Date Signed

**Section IV: Other Required Credentials**

**BLS (CPR) Credential**  
 Attach a copy of a valid / current BLS Credential  
 Expiration date must be **GREATER**  
 than your SC state EMT expiration date  
**BLS card MUST be one of the following:**  
 AHA: BLS for the Healthcare Professional  
 ARC: CPR for the Professional Rescuer  
 ASHI: CPR Pro

**SC State Criminal Background Check**  
 Attach a copy of your IBT  
 fingerprint receipt  
 You may call IBT at  
 866-254-2366  
 to make an appointment  
 SC DHEC EMS ORI #: SC920111Z

I hereby affirm that all statements on the SC EMT-Basic Recertification form are true & correct, including the copies of cards, certificates, and other required verification. It is understood that false statements or documents may be sufficient cause for revocation of my EMT credential by SC DHEC. It is also understood that SC DHEC may conduct a full audit of all recertification activities listed on this form at any time.

\_\_\_\_\_  
Signature of IST Training Director or EMS Service Director + Date Signed

\_\_\_\_\_  
Signature of EMT Recertification candidate + Date Signed