



Provider Information				
Loyola System Number		Name		
Provider Level: <input type="checkbox"/> EMT-B <input type="checkbox"/> EMT-B/D <input type="checkbox"/> EMT-P <input type="checkbox"/> First Responder <input type="checkbox"/> ECRN <input type="checkbox"/> Other				
Monthly Continuing Education				
Date	Lecture Topic - Month/Year	Test Topic- Month/Year	Pass/Fail	Hours
Specialty Course / Outside System Continuing Education *				
Course / Lecture Topic			Date	
Location		Site Code #	Credit Hours	
* Attach copy of certificate if issued				
Clinical Rotation				
Clinical Area			Date	
Preceptor		Time In-Out	Total Hours	
Describe a principle learned and how it will effect your practice:				
Course Instructor/Clinical Preceptor Signature			Date	
The above information is complete and accurate in accordance with the policies and procedures of the Loyola Emergency Medical Services System.				
Provider Signature			Date	



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