

Provider Information	
Loyola System Number	Name
Provider Level: ! EMT-B ! EMT-B/D ! EMT-P ! First Responder ! ECRN ! Other	

Monthly Continuing Education				
Date	Lecture Topic - Month/Year	Test Topic- Month/Year	Pass/Fail	Hours
Instructor Signature _____			Date _____	

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:		
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 _____

LEMSS office use only:			
Date _____	Initials _____	Total Hours Awarded	<input type="text"/>

Record of Continuing Education

