Continuing Medical Education - News & Information

Multi-Agency Edition

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Journal CME Newsletter
FDNY - Office of Medical Affairs

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Brooklyn, NY 11201
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From the Editor

** New Online Registration for REMAC Refresher Exam **

Go to www.planetReg.com/E31112555131510 (or www.nycremsco.org & click the REGISTER link under “News & Announcements”).

See the last page of this journal for details.

** July 1, 2012 REMAC Protocol revisions in effect **

Only the July 1, 2012 protocols are in effect in the field and on certification exams. (See page 2 for outline of changes.)

Always see nycremsco.org for the current approved protocols.

REMEMBER: the protocols on the street are the protocols on the exam!

** Mandatory REMAC Credentialing Fee **

A $25 fee has been instituted by NYC REMAC for all new or recertifying paramedic credentials. No fee is collected at the exam. After successfully completing a REMAC exam, candidates will receive an email directly from NYC REMSCO requiring a completed application and credentialing fee by money order only. On receipt, a permanent NYC REMAC certification card will be issued.

Please direct inquires on this process to NYC REMSCO at 212-870-2301
Outline of July 2012 NYC REMAC protocol changes
see REMAC Advisory 2012-01 at nycremsco.org

General Operating Procedures
• Transport: changes stroke criterion to 3½ hours from onset

BLS Protocols
• 400 WMD: updates language of evaluation and autoinjector configuration

ALS Protocols
• 500-A Smoke Inhalation: changes name of protocol and indication for its use
• 500-A Smoke Inhalation & 500-B Cyanide Exposure: adds Table 2 to clarify different hydroxocobalamin bottle configurations; removes administration time per individual bottles
• 503-A V-fib/V-tach: removes dilution of amiodarone
• 511 AMS: adds glucagon to note specifying glucometer levels for treatment
• 513 Seizures: clarifies that seizures must be generalized; adds glucagon to note specifying glucometer levels for treatment; adds glucagon option for diabetic patients
• 553 Peds Non-Traumatic Arrest: updates endotracheal intubation to advanced airway management
• 557 Peds Seizures: adds glucagon to note specifying glucometer levels for treatment; moves midazolam to Standing Orders for initial administration, increases dose, and specifies preference for intranasal route; defers rectal diazepam until all other options are exhausted
• 559 Peds Traumatic Arrest: updates endotracheal intubation to advanced airway management

Appendices
• Appendix R - Stroke Criteria: changes criterion to 3½ hours from onset
**REMAC Exam Study Tips**

REMAC candidates have difficulty with:

- *12-lead EKG interpretation* 10% BLS 15% Adult Trauma
- *ventilation rates for peds & neonates* 10% Adult Arrest 15% Pediatrics

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**Certification & CME Information**

- **Of the 36 hours of Physician Directed Call Review CME required for REMAC Refresher recertification, at least 18 hours must be ACR/PCR Review (which may include QA/QI Review). The remaining 18 hours may include ED Teaching Rounds and OLMC Rotation.**

- **Failure to maintain a valid NYS EMT-P card will invalidate your REMAC certification.**

- **By the day of their refresher exam all candidates must present a letter from their Medical Director verifying fulfillment of CME requirements. Failure to do so will prevent recertification.**

- **FDNY paramedics, see your ALS coordinator or Division Medical Director for CME letters.**

- **CME letters must indicate the proper number of hours, per REMAC Advisory # 2000-03:**
  - 36 hours - Physician Directed Call Review
    - ACR Review, QA/I Session (minimum 18 hours of ACR/QA review)
    - Emergency Department Teaching Rounds, OLMC Rotation
  - 36 hours - Alternative Source CME - Maximum of 12 hours per venue
    - Online CME - Clinical rotations
    - Lectures / Symposiums / Conferences - Associated Certifications:
      - BCLS / ACLS / PALS / NALS / PHTLS
    - Journal CME

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**REMAC Refresher Written examinations** are held monthly, and may be attended up to 6 months before your expiration date. See the exam calendar at the end of this Journal. To register, call the Registration Hotline @ 718-999-7074 by the last day of the month prior to your exam.

**New March 2013: REMAC Basic Written and Scenario examinations** are held monthly. Registration is limited to the first 25 applicants. See the exam calendar at the end of this journal.

**REMAC CME and Protocol information** is available, and suggestions or questions about the newsletter are welcome. Call 718-999-2671 or email swansoc@fdny.nyc.gov

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REMSCO: www.NYCREMSCO.org  
Online CME: www.EMS-CE.com  
www.EMCert.com  
www.WebCME.com  
www.EMINET.com
FDNY ALS Division Coordinators

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Mike Romps

Division 5 718-979-7175
Marissa Crocco

Bureau of Training 718-281-8325
Hector Arroyo / Lisa Desena

EMS Pharmacy 718-571-7620
Cindy Corcoran

FDNY EMS Medical Directors

Dr. Glenn Asaeda 718-999-2790
Chief Medical Director
OLMC Director, REMAC Coordinator

Dr. Dario Gonzalez 718-281-8473
Field Response Division 2
USAR/FEMA Director, OEM Liaison

Dr. David Ben-Eli 718-999-0404
Field Response Division 4
Haz-Tac, PASU & EMS Resident Director

Dr. Doug Isaacs 718-281-8428
Field Response Division 1
EMS Fellowship & Rescue Medic Director

Dr. Bradley Kaufman 718-999-1872
QA, EMD & EMS Training Director

EMS Fellows - Field Response Divisions 3 & 5
Dr. Faizan Arshad 718-999-0364

Dr. Alan Williams 718-999-0351

FDNY OLMC Physicians and ID Numbers

Alexandrou, Nikolaos 80282 Huie, Frederick 80300
Arshad, Faizan 80315 Isaacs, Doug 80299
Asaeda, Glenn 80276 Jacobowitz, Susan 80297
Barbara, Paul 80306 Kaufman, Bradley 80289
Bayley, Ryan 80314 Lai, Pamela 80311
Ben-Eli, David 80298 Munjal, Kevin 80308
Freese, John 80293 Redlener, Michael 80312
Friedman, Matt 80313 Rotkowitz, Louis 80317
Giordano, Lorraine 80243 Schenker, Josef 80296
Gonzalez, Dario 80256 Schnitzer, Leila 80241
Hansard, Paul 80226 Silverman, Lewis 80249
Hegde, Hradaya 80262 Soloff, Lewis 80302
Hew, Phillip 80267 Van Voorhees, Jessica 80310
Williams, Alan 80316
COMPUTERIZED TRIAGE

EMS care begins with the 911 call, which is well before the on-scene crew makes patient contact. In New York City, all 911 calls are processed at the Public Safety Answering Center (PSAC) which is located at 11 MetroTech Center in Brooklyn. An NYPD Police Communications Technician (PCT) performs the initial screening, and then, if there is a medical concern, as opposed to just police or fire issue, conferences in one of our EMS ARDs (Assignment Receiving Dispatchers). The ARDs are all EMTs or Paramedics who have undergone additional training to function in this role. It is a fast-paced and demanding position. The ARDs interact with many callers every hour who are angry, in pain, watching a loved one die, and likely having one of their worst life moments. In many ways, the ARDs stress of interacting with a patient on the phone can be more prolonged and intense than that of on-scene providers.

Besides verifying the address and location information, the ARD has the very important job of determining the call-type by asking a series of structured questions. The call-type determines what EMS resources are to be sent (ALS, BLS, and/or CFR) as well as the priority. This is a critical step in the EMS process because we have different levels of response and an overabundance of requests for EMS. If we only had one type of resource (e.g., BLS ambulances), and plenty of them standing by, then we could just simply assign each call immediately upon receiving it, in a first in first out type of model. This is how dispatch works in many areas of the country. In our system, we often have many more requests than available ambulances, and therefore have to triage our responses so that we try to minimize delays to the most ill patients. While the call-type gives some indication as to the patient’s complaint, this is not the main purpose. Rather it is intended to simply determine the level of EMS response and the priority, allowing the dispatcher to assign the appropriate units. In many cases, by design, the call-type does not seem to fit the complaint exactly. For instance, a patient having an acute myocardial infarction may have severe chest pain and associated sensation of shortness of breath. The appropriate call-type in this case would be DIFFBR (ALS priority 2) as opposed to CARD (ALS priority 3). Similarly, if a patient is having chest pain after trauma to his chest, the call-type would be INJMAJ (BLS priority 3), however if associated shortness of breath, it would again be DIFFBR (ALS priority 2). The point is that the call-type is not meant to be a presumptive diagnosis but a method of determining EMS resource assignments. In fact, the ARDs do not obtain a full history of present illness (HPI) or past medical history (PMH) as their goal is not to diagnose but to determine the call-type.

The call-type is derived after completing a series of structured and focused questions. This is an important point to stress because people may question the accuracy of a call-type not being aware that they are not meant to be a presumptive diagnosis. Often a better description of the patient’s condition, although still limited, can be
obtained by the responding crew while en route by reviewing the free text entered by the ARD into the CAD assignment’s job text. Of course, keep in mind that the patient information in the CAD may also have inaccuracies. Typically upon review of such inconsistencies, we find that the ARD did an excellent job documenting, however the information provided by the caller was inaccurate in regards to the patient’s condition. Obtaining an accurate HPI when face to face with a patient who is a poor historian can be challenging. Doing it over the phone adds extra levels of complexity.

Determining the call-type is an important part of the call-taking process, however providing pre-arrival instructions (PAIs) to the caller may be even more important and can make the difference between life and death. Once the call-type is determined, it is entered into CAD and electronically transmitted to the Dispatcher. However, the ARD remains on the phone with the caller to provide medical instructions. This does not delay an ambulance being assigned. The ARD will provide general instructions, such as “send someone to meet the ambulance,” as well as condition specific instructions such as directing bystander chest compressions for a patient in cardiac arrest. In some situations the ARD will remain on the line with the caller until the ambulance arrives, such as in the case of a cardiac arrest, suicidal caller, child caller at home alone, and others. More often, upon completion of pre-arrival instructions, the ARD will disconnect after advising the caller that “an ambulance will be there as soon as possible.”

Like the REMAC protocols, the telephone triage algorithms and call-types are frequently updated. Medicine is dynamic and may require that certain calls warrant a different priority or level of response (i.e., ALS or BLS). Furthermore, we sometimes add or delete entire call-types in order to better coordinate the EMS response that is required.

In early December, we will be adding two new call-types: INJALS and OBMAJ. Currently, patients who have sustained an injury to their head, hip, pelvis, thigh, back, shoulders, or eyes are call-typed as INJURY (BLS priority 5). Although more severe head injuries with altered mental status are classified as INJMAJ (BLS priority 3). Injuries to a person’s arm, elbow, hand, knee, lower leg, foot, or ankle are call-typed as INJMIN (BLS priority 7). We have identified a subset of patients who are typically elderly and had fallen and sustained a hip or femur fracture, as often may occur in geriatric patients who have weak and brittle bones. In many cases these patients have been on the floor overnight and are found there when a family member or friend arrives the following day. Such patients often benefit from receiving intravenous pain medication and sometimes intravenous fluids prior to transport. Therefore, we are introducing the INJALS call-type (ALS priority 3) to be used when an ARD identifies such a patient.
We have rearranged some of the call-types in regards to obstetrical patients and have added the call-type OBMAJ which will have a BLS priority 3 response. Because we have added this BLS call-type, we have changed the OBCOMP call-type from a BLS priority 2 response to an ALS priority 2 response. Prior to the change, a report of a pregnant patient having a seizure was call-typed as a STATEP (ALS priority 2). Now it will be call-typed as an OBCOMP (ALS priority 2). So you can see that there is actually no change in the level or priority of response, but in this case is just a semantics change that hopefully provides clarification. Because of the similar concern for eclampsia where intravenous magnesium can be life-saving, a pregnant woman suffering from headache and blurred vision will receive a call-type of OBCOMP (ALS priority 2). Previously this was call-typed as ALTMEN (ALS priority 3). A patient with a known high risk pregnancy but none of the above symptoms will now be changed from a call-type of OBCOMP (BLS priority 2) to a call-type of OBMAJ (BLS priority 3). OBMAJ (BLS priority 3) will also be the call-type for pregnant women with greater than 20 week gestation who are having vaginal bleeding (previous call-type of OBCOMP (BLS priority 2)) as well as pregnant women having abdominal pains or contractions with gestation of less than 20 weeks (previously call-type of ABDPN (BLS priority 5)).

There are two important thoughts that many of you will likely have after reading the above discussion. First, how is the field provider supposed to keep straight the ever evolving world of Emergency Medical Dispatch (EMD) triage and call-types? It is often enough of a challenge just keeping up to date with the REMAC protocol changes. The answer, as briefly discussed above, is that the field provider does not have to worry about the intricacies of call-type determinations. Call-types are mainly to coordinate the appropriate dispatch of EMS resources. Once the ambulance is dispatched and the providers arrive at the scene, they should assess the patient starting with a chief complaint and performing a full history and physical (H&P) as necessary. Again, we know that call-types may be incorrect. We know that callers often provide us with inaccurate information. None of that matters once the EMS providers are with the patient and they have the opportunity to get better information.

There is an important cognitive bias called ‘anchoring’ which describes the human tendency to rely too heavily, or ‘anchor,’ on one piece of information when making decisions. For example, a crew is dispatched to a call with a CVA call-type. They note neurological deficits, and ‘anchor’ on the presumptive diagnosis of stroke even though the patient has fever and neck stiffness that may make meningitis a more likely diagnosis. Furthermore, the EMS diagnosis sometimes becomes anchored to the patient throughout his or her Emergency Department (E.D.) management and hospitalization. We have reviewed many cases where a missed call-type (again, not the fault of the ARD) was carried through the PCR, E.D. triage note, and E.D. physician management. The way to overcome anchoring is by forcing oneself to develop a broad differential diagnosis based upon your own assessment of the patient and to limit the differential by **objective clinical findings**. So now I hope it is clear that
the introduction and explanation of the new call-types in this article can provide you some awareness, but does not require the field provider to memorize the clinical reasoning behind them or base your patient assessment or treatment on them.

The second thought many of you may have after reading the brief explanation of the new call-types is; how is an ARD supposed to keep this all straight? The triage algorithms are currently maintained on flip cards at each call receiving workstation. The ARDs reference these cards to determine the call-types. However, as our algorithms have gotten more complex the flip card methodology has become increasingly cumbersome. Therefore the FDNY has been working with the Mayor’s Office of Citywide Emergency Communications (OCEC) to change over to a computerized triage application (CTA) where the questions will appear on the computer monitor in a priority order yielding the call-type as soon as it can be determined. Not only should this make the process more efficient for the ARDs, it allows the questioning to become more focused on the medicine that underlies the call-type determinations. Using CTA we can create much more complex algorithms which seamlessly direct specific questions based on previous answers. Such algorithms are not possible when using a paper flip card process.

While the CTA has been programmed and the background testing completed, we still want to carefully integrate it into the live call-taking environment. So, over the next few months as a pilot, we will use the CTA on a sample of 911 calls. The majority of calls will still be call-typed using the current methodology. Once the pilot is completed and evaluated, and if it meets our goals, then we can use the CTA on all calls.

The CTA also automatically passes along medical information from the call to the CAD. Currently the information is added manually by the ARD into the CAD’s job text. Field crews will notice a difference in the format of the job text which will require some time for familiarization. Again, regardless of the accuracy or inaccuracy of the job text, it is imperative that you do a full patient assessment starting with a chief complaint upon making patient contact.

One last point of clarification. Early on in the conversation, the ARD asks a caller the age of the patient. Patient age is extremely important in determining the call-type and the appropriate PAIs to give. Also, it is important to have the age entered into the CAD for the responding crew to see, not only to be sure to have appropriate equipment but also to help identify the patient once on-scene. Are you looking for a 10 year-old or a 65 year-old patient? Sometimes a caller does not know the age of the patient. For instance, they see a teenager lying on the street. The caller doesn’t know if the patient is 14 years old, 15 years old, etc. We prompt them for an age category in these circumstances. The table below shows the age categories and the corresponding ages.
These age categories help guide the EMD process and also should help the responding crew. Of course, regardless of the age or age category entered into CAD, the on-scene providers should try to ascertain an accurate patient age and apply the appropriate REMAC protocols: pediatric protocols for patients aged 13 and below and adult protocols for patients aged 14 and above.

In summary, EMS patient contact starts with the ARD on the phone with the caller. The field providers should understand the call-typing process and the administration of PAIs. All medical providers must try to prevent ‘anchoring’ and instead develop a broad differential diagnosis. Like REMAC protocols, triage algorithms whether on flip cards or in a CTA require continuous updates to stay current with medicine and evolving requests for emergency medical care.

**Written by:** Bradley Kaufman, MD, MPH  
Medical Director, FDNY Bureau of Training

<table>
<thead>
<tr>
<th>Age Related Terms for EMD Triage</th>
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<tr>
<td><strong>Neonate</strong> - less than 4 weeks old</td>
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<td><strong>Infant</strong> - 4 weeks up to less than 1 year old</td>
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<td><strong>Toddler</strong> - 1 year up to less than 3 years old</td>
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<td><strong>Child</strong> - 3 years up to less than 13 years</td>
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<td><strong>Teenager</strong> - 13 years up to less than 18 years</td>
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<td><strong>Adult</strong> - 18 years up to less than 65 years</td>
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<td><strong>Elderly</strong> - 65 years or older</td>
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1. The goal of the call-type is to:
   a. Provide a presumptive diagnosis
   b. Determine EMS resource assignment
   c. Enable response time data comparisons
   d. Collect data for system evaluation

2. Assignment Receiving Dispatchers
   a. Receive additional telecommunication training
   b. Obtain past medical history of patients
   c. Always stay on the line with the caller until the ambulance arrives
   d. Do not have patient contact

3. Anchoring can cause bias by
   a. Delaying transport of a patient
   b. Creating a broad differential diagnosis
   c. Requiring the EMT to perform a full H & P
   d. Having the EMT rely too heavily on one piece of information.

4. The Computerized Triage Application will allow the ARD to
   a. Ask a series of questions presented by the program to determine the call-type
   b. Dispatch appropriate EMS resources to the assignment
   c. Allow callers to choose their own call-type
   d. Assist with START during an MCI

5. A neonate is any child up to one year of age.
   a. True
   b. False
6. The call-type INJALS will have which dispatch assignment?
   a. BLS priority 2
   b. BLS priority 3
   c. ALS priority 3
   d. Dual response

7. The call-type OBMAJ will have which dispatch assignment?
   a. BLS priority 2
   b. BLS priority 3
   c. ALS priority 3
   d. Dual response

8. A call to 911 is made to request an ambulance to a doctor’s office where a patient is having chest pain, shortness of breath, diaphoresis, and ST elevations on ECG. The most appropriate call-type would be
   a. CARD
   b. RESPIR
   c. DIFFBR
   d. SICK

9. The call-types are determined by REMAC protocols.
   a. True
   b. False

10. A high school student has fallen and the caller does not know the patient’s age. What age-related term would be most appropriate?
    a. Child
    b. Teenager
    c. Adult
    d. Unknown age
Based on the CME article, place your answers to the quiz on this answer sheet. Respondents with a minimum grade of **80%** will receive **1 hour** of Online/Journal CME.

Please submit this page **only once**, by one of the following methods:
- FAX to 718-999-0119 or
- MAIL to FDNY OMA, 9 MetroTech Center 4th flr, Brooklyn, NY 11201

Contact the Journal CME Coordinator at 718-999-2790:
- three months before REMAC expiration for a report of your CME hours.
- for all other inquiries.

*Monthly receipts are not issued. You are strongly advised to keep a copy for your records.*

Note: if your information is illegible, incorrect or omitted you **will not** receive CME credit.

Check one: □ EMT □ Paramedic □ other

Name

NY State / REMAC # or “n/a” (not applicable)

Work Location

Phone number

Email address

Submit answer sheet by the last day of January 2014

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<th>Dec 2013 – Jan 2014 CME Quiz</th>
<th>All questions for all providers</th>
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## Citywide CME - December 2013 - January 2014

*Sessions are subject to change without notice. Please confirm through the listed contact.*

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<td>ED Conference Room</td>
<td>Dr Hew</td>
<td>Manny Delgado 718-363-6644</td>
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<td>Dr Brandler</td>
<td>Aaron Scharf 718-780-1859</td>
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<td></td>
<td>Lutheran</td>
<td>4&lt;sup&gt;th&lt;/sup&gt; Wed</td>
<td>1730-1930</td>
<td>Call Review RSVP →</td>
<td>Call for location →</td>
<td>Dr Chitnis</td>
<td>Dale Garcia 718-630-7230</td>
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<td>Dr Williams</td>
<td>RSVP: <a href="mailto:ssamuels@nyp.org">ssamuels@nyp.org</a></td>
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<td>Ana Doulis 212-746-0885 x2</td>
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<td>Schwartz Lecture Hall</td>
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<td>Jessica Kovac 212-263-3293</td>
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<td>1&lt;sup&gt;st&lt;/sup&gt; Wed</td>
<td>1300-1400</td>
<td>Call Review: Trauma Rounds</td>
<td>A1-22 Auditorium</td>
<td>TBA</td>
<td>Anju Galer, RN 718-334-5724</td>
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<td>Mt Sinai Qns</td>
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<td>1800-2100</td>
<td>Lecture or Call Review</td>
<td>25-10 30 Ave, conf room</td>
<td>Dr Dean</td>
<td>Donna Smith-Jordan 718-267-4390</td>
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<td>East bldg, courtyard flr</td>
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<td>Judith Brown 718-869-7223</td>
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<td>RUMC</td>
<td>TBA</td>
<td>1400</td>
<td>TBA: call to inquire →</td>
<td>MLB conf room</td>
<td>TBA</td>
<td>William Amaniera 718-818-1364</td>
</tr>
<tr>
<td></td>
<td>SIUH North</td>
<td>TBA</td>
<td>TBA</td>
<td>TBA: call to inquire →</td>
<td>Regina McGinn Center</td>
<td>TBA</td>
<td>Andrea Kleboe 718-226-7878</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>475 Seaview Ave</td>
<td></td>
<td><a href="mailto:pbarbara.md@gmail.com">pbarbara.md@gmail.com</a></td>
</tr>
<tr>
<td></td>
<td>SIUH South</td>
<td>TBA</td>
<td>TBA</td>
<td>TBA: call to inquire →</td>
<td>346 Seguine Ave</td>
<td>Dr Barbara</td>
<td>917-903-7475</td>
</tr>
</tbody>
</table>
### 2014 NYC REMAC Examination Schedule

<table>
<thead>
<tr>
<th>Month</th>
<th>Registration Deadline</th>
<th>Refresher exams*</th>
<th>Basic exams**</th>
<th>NYS/DOH Written Exam***</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Written exam only</td>
<td>Written &amp; Scenario exams</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CME letter required</td>
<td>Sundays 09:30-16:00</td>
<td></td>
</tr>
<tr>
<td>January</td>
<td>1/1/14</td>
<td>1/22 @10:00</td>
<td>1/26/14</td>
<td>1/16/14</td>
</tr>
<tr>
<td>February</td>
<td>2/1/14</td>
<td>2/18 @18:00</td>
<td>2/23/14</td>
<td>2/20/14</td>
</tr>
<tr>
<td>March</td>
<td>3/1/14</td>
<td>3/18 @18:00</td>
<td>3/23/14</td>
<td>3/20/14</td>
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<tr>
<td>April</td>
<td>4/1/14</td>
<td>4/22 @18:00</td>
<td>4/27/14</td>
<td>4/17/14</td>
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<tr>
<td>May</td>
<td>5/1/14</td>
<td>5/15 @18:00</td>
<td>5/18/14</td>
<td>5/15/14</td>
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<tr>
<td>June</td>
<td>6/1/14</td>
<td>6/19 @10:00</td>
<td>6/22/14</td>
<td>6/19/14</td>
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<tr>
<td>July</td>
<td>7/1/14</td>
<td>7/20 @10:00</td>
<td>7/24/14</td>
<td>7/17/14</td>
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<tr>
<td>August</td>
<td>8/1/14</td>
<td>8/20 @10:00</td>
<td>8/31/14</td>
<td>8/21/14</td>
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<tr>
<td>September</td>
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<td>9/16 @18:00</td>
<td>9/21/14</td>
<td>9/18/14</td>
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<tr>
<td>October</td>
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<td>10/26/14</td>
<td>10/23/14</td>
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<tr>
<td>November</td>
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<td>11/23/14</td>
<td>11/20/14</td>
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<tr>
<td>December</td>
<td>12/1/14</td>
<td>12/17 @10:00</td>
<td>12/28/14</td>
<td>12/18/14</td>
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</tbody>
</table>

* The REMAC Refresher Written examination is offered for paramedics who meet CME requirements and whose REMAC certifications are either current or expired less than 30 days. To enroll, go to the REGISTER link under “News & Announcements” at nycremsco.org before the registration deadline above. Candidates may attend an exam no more than 6 months prior to expiration.

** REMAC Basic Written & Scenario examination is for initial certification, or inadequate CME, or certifications expired more than 30 days. Seating is limited. Registrations must be postmarked by the deadline above. Exam fee is $100 by money order. Email Christopher.Swanson@fdny.nyc.gov for instructions.

*** NYS/DOH exam dates are listed for information purposes only. Scheduling is through your paramedic program or contact NYS DOH for more information.