**Online Registration for REMAC Refresher Exam – see below**

Continuing Medical Education - News & Information  
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Multi-Agency Edition  
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**From the Editor**

**New Online Registration for REMAC Refresher Exam**

Go to [www.planetReg.com/E31112555131510](http://www.planetReg.com/E31112555131510) (or [www.nycremsco.org](http://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](http://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 inquiries 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:

* Epinephrine use for peds patients
* 12-lead EKG interpretation
* Ventilation rates for peds & neonates

REMAC Written exams are approximately:

10% BLS  10% Adult Trauma
10% Adult Arrest  15% Pediatrics

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
    - Lectures / Symposiums / Conferences
    - Journal CME

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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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
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Giordano, Lorraine 80243  Schenker, Josef 80296
Gonzalez, Dario 80256  Schnitzer, Leila 80241
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Diabetes mellitus is a very common disease. It affects more than 25.8 million Americans, both adults and children. It is a disorder of glucose metabolism. Without treatment, blood glucose levels can become too high and can cause coma and death. With proper treatment, most people can live a normal life, but they must be willing to adjust their lives to the demands of the disease. They must monitor their eating habits and their activities. However diabetes can have severe complications that affect the length and quality of life, including blindness, cardiovascular disease, and kidney failure.

When you are sent to the scene of a diabetic emergency, your job will not be to diagnose or treat diabetes but rather to recognize and treat a condition that diabetes, or the poor management of diabetes, has caused. The first indication that the patient is a diabetic may be an altered mental status. There can be other clues as well, such as medic alert tags, insulin, or other diabetic medications in the refrigerator or purse. You can also obtain information about the patient from the family, friends, or co-workers. A patient with a diabetic emergency may have a range of signs and symptoms. Many of these may mimic other, more commonly encountered conditions. The treatment of diabetes mellitus consists of drug therapy (insulin or hypoglycemic agents), diet regulation, and exercise. These therapies allow patients to control their glucose levels. They can also help restore normal metabolism.

As a prehospital provider, you need to know the signs and symptoms of a blood glucose level that is either too high or too low so that you can administer the proper lifesaving treatment.

**Diabetes Mellitus**

**What is Diabetes Mellitus?** Diabetes Mellitus is a disease in which the pancreas does not produce enough insulin or when the body loses the ability to utilize insulin properly. This lack of insulin or the body’s inability to utilize insulin properly causes a disorder of glucose metabolism or difficulty metabolizing carbohydrates, fats, and proteins.
Insulin is a hormone produced by the islets of Langerhans (endocrine glands) which are on the pancreas. The pancreas is a solid organ which requires a great deal of blood flow to function correctly. It is a tubular gland situated behind the stomach. Without insulin or a sufficient amount of insulin, glucose cannot enter the cells of the body. Insulin acts as a cellular key that allows glucose to enter the cells of the body.

Glucose is the body’s primary source of energy. It is a simple sugar that is obtained from the digestion of foods and must be incorporated into the body’s cells to supply energy. Many cells in the body are able to store glucose (in the form of glycogen), and are able to survive for short periods with a decreased blood flow and decreased glucose supply. The brain, however, is not able to survive because it is not able to store glucose. A constant supply of glucose is as important as oxygen to the brain. Without glucose, the brain cells suffer permanent damage.

Classifications of Diabetes Mellitus

Type I (IDDM)

- Insulin dependent diabetes mellitus (IDDM)
- The pancreas does not produce insulin or the body is unable to utilize insulin properly
- These patients must take insulin injections everyday
- May become evident when the patient is a child, or it may develop in later life, when patient is middle-aged

Type II (NIDDM)

Non-Insulin Dependent Diabetes Mellitus

- Usually appears later in life
- Patients produce inadequate amounts of insulin or they may produce a normal amount but the insulin does not function effectively
- Most patients can be treated by a diet, exercise, and non-insulin type oral medications
Some of the medications which can be taken are Glyburide, Diabinase, Glucophage, Glucotrol, and Avandia
- These types of medications stimulate the pancreas to produce more insulin and thus reduce blood glucose levels

**Diabetic Emergencies**

**Hypoglycemia** is a below normal range of glucose in the blood which is typically caused by administration of too much insulin, excessive secretions of insulin by the islets of Langerhans of the pancreas, or dietary deficiency. It is usually a sudden, rapid onset. Other causes of hypoglycemia can be as follows:

- Over exercising or overexerting oneself, thus using sugars faster than normal
- Vomiting
- Illness can reduce the glucose levels due to a lack of appetite
- The patient has taken insulin but missed a meal

**Signs & Symptoms**
Rapid onset of altered mental status
Intoxicated appearance, staggering, slurred speech, or complete unresponsiveness
Dizziness, weakness, or shakiness
Headache or hunger
Blurred vision
Irritability
Cool clammy skin
Anxiety
Seizures
Uncharacteristic behavior (e.g., combativeness)

If hypoglycemia is left untreated, it can rapidly develop into a serious condition known as **insulin shock**, which is the extreme case of hypoglycemia. The signs and symptoms of hypoglycemia can develop quickly over a time frame of 30 minutes to 2 hours. It is important to know that hypoglycemia is a rapid onset of signs and symptoms that can mimic many other diseases we encounter in the field.
The brain cells are very sensitive to glucose levels. If hypoglycemia is left untreated for too long the brain cells will die.

Hyperglycemia is high blood sugar. It is usually caused by a decrease in insulin, which leaves sugar in the bloodstream rather than allowing it to enter the cells. The insulin deficiency may be due to the body’s inability to produce insulin or may exist because the insulin injection was forgotten or not enough insulin taken. Infection, stress, or increasing dietary intake can also be a factor in hyperglycemia. Hyperglycemia can take from 24 hours to 72 hours to get to the point where the patient begins to show obvious signs and symptoms. It is a gradual onset.

**Signs & Symptoms**
- Polyuria (frequent urination)
- Polydipsia (increased thirst)
- Polyphagia (increased hunger)
- Altered Mental Status
- Headache
- Abdominal cramping
- Rapid pulse
- Warm, red, dry skin
- Nausea & Vomiting
- Dehydration
- Weakness
- Fruity odor to breath
- Rapid, deep respirations (Kussmaul’s Respirations)
- Unconsciousness (diabetic coma-DKA)

**Diabetic Ketoacidosis (Diabetic Coma),** a condition that develops when hyperglycemia is left untreated. It is a condition in which an absence of insulin causes the body to metabolize other sources of energy such as fat. The blood becomes acidic and the signs and symptoms that may be seen are fruity breath odor, AMS, rapid deep respirations (Kussmaul's respirations) and unconsciousness.
Now that we have discussed DIABETES MELLITUS, what this condition is, what the signs and symptoms that are commonly seen, let’s discuss how we can assess this patient in the pre-hospital setting.

Your assessment starts as you enter the scene of the call and complete your scene size up.

Scene Size-Up - As you approach the patient, look to see how you find him or her? Are they seated with eyes open or lying motionless on the ground? In what environment did you find the patient? Is there a potential for injury to that patient? If you suspect c-spine injury, maintain spinal precautions.

Assess your patient’s mental status using the AVPU SCALE
A-ALERT
V-RESPONS TO VERBAL STIMULI
P-RESPONS TO PAINFUL STIMULI
U-UNRESPONSIVE

Perform the initial assessment: and continue with your patient assessment.

After patient evaluation, EMT-Bs can determine if medics are required and what type of transportation is needed (rapid or delayed). You must now perform your History of Present Illness (HPI) and SAMPLE.

If your patient is AMS, and cannot provide the information you need, then ask family members, friends, bystanders, or caregivers that may be on the seen.

- **The description of the episode** What were the events that led up to you calling 911?
- **Onset** What were they doing when this happened?
- **Duration** How long they been like this?
- **Associated Symptoms** What else was bothering the patient?
- **Evidence of trauma** Did they fall? Did they get hurt in any way?
- **Interventions** Was anything done or given to the patient to help them? Did the intervention help?
- **Seizures** Did the patient have a seizure?
- **Fever** Has the patient been sick? Has he or she had a fever?
There are so many other questions that can be asked. It is up to you as the EMT on the scene to ask. You are the private eye on this case you have to dig for information because there are so many reasons why a patient can be altered mental status.

**Don’t forget your SAMPLE questions!**
S-signs& symptoms
A-allergies
M-medications
P-past pertinent medical history
L-last oral intake
E-events leading to injury or illness

LOOK AROUND THE HOUSE! LOOK IN THE MEDICINE CABINETS! LOOK IN THE REFRIGERATOR FOR INSULIN VIALS, LOOK FOR CLUES.

If the patient appears to have a traumatic injury or if the patient is believed to have a medical condition, and is unresponsive and we cannot obtain a medical history, a physical exam must be performed. This may help find hidden injuries or medical alert devices that can help us determine why the patient has an altered mental status.

A Glucometer is a device used to measure the blood glucose level in patients. The normal glucose reading is 80-120mg/dl. Typically, symptoms of hypoglycemia (low blood sugar) are not evident until 50mg/dl.

**Treatment for the Altered Mental Status Diabetic Patient**

Observe spinal injury precautions, if appropriate.
As with any other patient, monitor the airway and assure its patency.
Administer oxygen
Request ALS, if appropriate.
If patient is conscious, is able to swallow, and is able to drink without assistance, provide a glucose solution, fruit juice, or non-diet soda by mouth.
Do not give oral solutions to unconscious patients.

Do not give oral solutions patients with head injuries.

The treatment for hypoglycemia and for hyperglycemia in the pre-hospital setting for EMTs is the same as long as your patient is conscious and can swallow.

Continue to monitor your patient enroute to the emergency department.

**Conclusion**

Diabetes is a disease that can be controlled by diet, exercise and medications. Proper assessment of the Diabetic Patient with an altered mental status is possible. You can save a life.

**Written by:** Mildred Ramos, EMT-B, CLI
FDNY Bureau of Training

**References:**

Emergency Care and Transportation of the sick and Injured  
*Ninth edition*-Jones and Bartlett Publishers

Emergency Medical Technician: Making the Difference  
Mosby 2007

EMT Complete-A Basic Work Text  
Limmer & Lebadour

**Diabetes Emergencies, part II**

Diabetes is something that each and every one of us has encountered in our daily lives, on or off the job. It is a plague that is growing in numbers each and every year in the U.S. We treat countless AMS-Hypoglycemic patients in a single day. Most of us brush it off and continue our day, while others dwell on how to make it better.
When we treat an episode of hypoglycemia, knowledge of what happens physiologically makes for better understanding. As providers we can educate the patient and take advantage of that teachable moment.

**Dawn Phenomenon vs. Somogyi Effect**

Most of our AMS-runs in the field are largely due to over-medicating and under-eating, which in turn becomes a hypoglycemic emergency. As emergency medical providers, we should not only understand the illness itself, but also understand the different adverse effects dieting and medications have on each individual in the categories mentioned above.

**Dawn phenomenon** a.k.a. Dawn effect is an early morning influx of glycogen stores released into the blood stream, due to recognition of low blood sugar levels, and waning insulin levels. This phenomenon usually occurs between the hours of 2-8 a.m. What typically happens is the patient eats a carbohydrate rich snack, or meal prior to sleep. During this time, the insulin injected earlier wasn’t sufficient to assist transference of serum glucose into the cells for the duration of the sleep cycle. The body’s response to sugar not entering the cell is to release glycogen from storage. As the body recognizes this as insufficient serum glucose, epinephrine, cortisol, and glucagon have a major role in this physiological response. This hormonal surge further antagonizes insulin. This is a self preservation mechanism the body has when the cells lack sugar.

Dawn phenomenon can be managed in many patients by avoiding carbohydrate intake at bedtime, adjusting the dosage of medication or insulin, switching to a different medication, or by using an insulin pump to administer extra insulin during early-morning hours. In most of the cases, there is no need to change insulin dosing of patients who encounter dawn phenomenon.

**Somogyi Effect** also called Chronic Somogyi Rebound, or Post-hypoglycemic hyperglycemia on the other hand is a result of an over abundant usage of insulin at night and throughout the day.

Rebound hyperglycemia is the body’s natural response to too much insulin. Although most of the body’s response has similarities to Dawn Phenomenon, (i.e. hormone surge releasing glycogen due to low insulin) its response is strictly due to over medicating. Too much insulin puts the body into harms
way by lowering serum glucose into an emergent state. Growth hormones such as epinephrine, cortisol, and glucagon, sound the alarm, and tell the liver to release glycogen to prevent catastrophic events (death).

Early morning glucose checks may be abnormally high. This is due to the body’s constant release of glycogen stores This phenomenon can be prevented by frequent glucose checks, and learning how to adjust insulin appropriately in conjunction with doctor’s recommendations. Most of you have seen patients with glucose check log books! It just might be for this reason.

Written by:  Hiram Colon, EMT-P, CIC
FDNY Bureau of Training

References:

Emergency Care and Transportation of the sick and Injured
_Ninth edition-Jones and Bartlett Publishers_

Emergency Medical Technician: Making the Difference
_Mosby 2007_

EMT Complete-A Basic Work Text
_Limmer & Lebautour_

Paramedic Practice Today – Above and Beyond
_Mosby-JEMS-Aehlert 1st Edition_

American Association of Diabetes.org

WebMD.com
Questions 1-5 for BLS and ALS providers

1. A diabetic patient who has eaten regular meals over the past several hours but has not taken his medication will most likely develop:
   a. hypoglycemia
   b. insulin shock
   c. hyperglycemia
   d. diabetic shock

2. Which is a contraindication for administering oral glucose to a known diabetic patient?
   a. low blood glucose readings
   b. an unresponsive patient
   c. the patient is able to swallow easily
   d. the patient has taken insulin recently

3. What major avoidances or changes can a patient take in order to prevent Dawn Phenomenon?
   a. avoiding carbohydrate intake prior to bedtime
   b. adjusting medication, or insulin
   c. utilizing an insulin pump to administer extra medication when needed
   d. all of the above

4. Dawn Phenomenon is mostly caused by:
   a. insufficient insulin administration
   b. over medicating with insulin
   c. consuming carbohydrates prior to bedtime
   d. both a and c

5. Somogyi, also called rebound hyperglycemia, occurs because of what patient action?
   a. insufficient insulin administration
   b. over medicating with insulin
   c. inadequate dieting
   d. consuming too many carbohydrates prior to bedtime.
Questions 6-10 for ALS providers, refer to NYC REMAC protocol

6. What specific ALS assessment for the altered mental status patient is required prior to administering medications under REMAC protocol?
   a. ECG
   b. pulse oximetry
   c. glucometer
   d. none of the above is required

7. When the glucometer reading is above what level should dextrose and glucagon should be withheld?
   a. 80 mg/dl
   b. 100 mg/dl
   c. 110 mg/dl
   d. 120 mg/dl

8. Which is a standing order for adult AMS patients?
   a. IO infusion of normal saline
   b. dextrose 25 gm (25 ml of a 50% solution), saline lock bolus
   c. glucagon 1 mg, IV bolus
   d. naloxone 0.8 mg, IN

9. Per protocol, how many total attempts may be made for vascular access in the pediatric AMS patient?
   a. 1
   b. 2
   c. 3
   d. no limit

10. For pediatric AMS patients, which is a correct administration of dextrose?
    a. D50 in patients greater than 10 years of age
    b. D25 in patients less than 10 years of age
    c. D10 in patients less than 1 month of age
    d. all of the above
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 October

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<th>CME Quiz</th>
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<td>Questions 1-5 for all providers</td>
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# Citywide CME – October 2013

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>Lutheran</td>
<td>4th Wed</td>
<td>1730-1930</td>
<td>Call Review RSVP →</td>
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<td>Dr Chitnis</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>1800-2100</td>
<td>Lecture or Call Review</td>
<td>25-10 30 Ave, conf room</td>
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<td>Donna Smith-Jordan 718-267-4390</td>
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<td>Mary Ellen Zimmermann RN</td>
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<td>Judith Brown 718-869-7223</td>
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<td>SI</td>
<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>
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<td></td>
<td></td>
<td>475 Seaview Ave</td>
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<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><a href="mailto:pbarbara.md@gmail.com">pbarbara.md@gmail.com</a></td>
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<td>917-903-7475</td>
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# 2013 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>
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<tbody>
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<td>weekly exams</td>
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### Refresher exams
- Written exam only
- CME letter required

### Basic exams
- Written & Scenario exams
- Sundays 09:30-16:00

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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.

The **REMAC Basic Written & Scenario examination** is for initial certification, or inadequate CME, or for certifications expired more than 30 days. Seating is limited and registrations must be postmarked by the deadline above. A $100 exam fee by **money order** is required. Email swansoc@fdny.nyc.gov for instructions.