London Health Sciences Centre
Southwest Ontario Regional Base Hospital Program

ONTARIO BASE HOSPITAL GROUP
CROSS-CERTIFICATION REQUEST FORM
(Current/Most Recent Employment)

PART A: PARAMEDIC INFORMATION		*To be completed by the paramedic*
First Name:	Last Name:	Former Last Name:
EHS #:	Telephone Number:	
Email Address:	Work Email Address:	
Educational Institution:	Program Title:	
City:	Province:	Year of Graduation:
Would you like to attach an educational certificate? ☐ Yes ☐ No		
Base Hospital currently certified at:		
Certification History: *Must include ALL Base Hospital(s) previously certified at.*		Year:
		Year:

Has your ability to practice as a paramedic even been denied, reduced, suspended or revoked by anyone for reasons other than an absence from clinical practice (e.g. parental leave, injury leave)? If yes, please explain: _____ Base Hospital/College of Paramedicine/ Other regulatory or delegating authority name: _____ Date: _____ Certification Level: _____	☐ Yes ☐ No
Have you ever been the subject of disciplinary proceedings, a decertification process or medical-legal litigation (e.g. negligence or malpractice)? If yes, please explain: _____ Base Hospital/College of Paramedicine/ Other regulatory or delegating authority name: _____ Date: _____ Certification Level: _____	☐ Yes ☐ No
Is your ability to practice as a paramedic currently being restricted or investigated by a Base Hospital? Is your ability to practice as a paramedic currently being restricted or investigated by a Base Hospital? If yes, please explain: _____ Base Hospital/College of Paramedicine/ Other regulatory or delegating authority name: _____	☐ Yes ☐ No
Have you every voluntarily ceased to practice paramedicine? If yes, please explain: _____ Date: _____	☐ Yes ☐ No
Are you a member of any another health care-providing profession (e.g. PSW, Registered Nurse)? If yes, please explain: _____	☐ Yes ☐ No

PART B: DECLARATION AND RELEASE OF INFORMATION AUTHORIZATION *To be completed by the paramedic*

In making this Certification Request,

1. I declare that the information I have provided is true and accurate to the best of my knowledge.

2. I acknowledge that falsification of records and misrepresentation of facts are grounds for withholding certification or decertification.

3. I consent to any person or organization disclosing of all information, including personal information, regarding my education, performance, licensure and certification to the Southwest Ontario Regional Base Hospital Program so that the Southwest Ontario Regional Base Hospital Program may validate and evaluate my Certification Request.

I consent to the Southwest Ontario Regional Base Hospital Program disclosing to anyone my certification status (e.g. Consolidation, Certification including level of care and flight or land designation, Deactivation, Administrative Decertification or Clinical Decertification).

In addition, I consent to the Southwest Ontario Regional Base Hospital Program disclosing to any other Base Hospital, College of Paramedicine, or other regulatory or delegating authority the reasons for my status (e.g. Deactivation because of a Patient Care Concern, Clinical Decertification for falsification of medical records, etc.)

I authorize the ongoing release of information to the Southwest Ontario Regional Base Hospital Program from other Base Hospitals regarding my count of patient care contacts for the purposes of maintenance of certification.

I understand that checking this box has the same binding effect as a signature ☐ Date: _____

PART C: CERTIFICATION INFORMATION *To be completed by all current/previous Base Hospitals*

Current/Most Recent Employment

Base Hospital:		
Employer Name:		
Most current scope of practice:	☐ Primary Care Paramedic	Date of Initial Certification:
	☐ Advanced Care Paramedic	Date of Initial Certification:
	☐ Primary Care Flight Paramedic	Date of Initial Certification:
	☐ Advanced Care Flight Paramedic	Date of Initial Certification:
	☐ Critical Care Paramedic	Date of Initial Certification:
Last Mandatory CME:		Decertification/Departure Date:
Last ACR record where care was provided:		

Has this paramedic ever been deactivated/decertified by a Medical Director for issues surrounding their Paramedic Certification or had his/her ability to practice paramedicine denied, reduced, suspended or revoked for reasons other than an absence from clinical practice (e.g. parental leave, injury)? If yes, please complete the section below:	☐ Yes ☐ No

Date of Deactivation/ Decertification:	Type of Deactivation/ Decertification:	Certification Level:

Has this Paramedic been the subject of disciplinary proceedings or medical-legal litigation (e.g. negligence or malpractice)? If Yes, please explain: _____	☐ Yes ☐ No

PART D: CURRENT AUXILIARY MEDICAL DIRECTIVES AND AUXILIARY MEDICATION CERTIFICATION

To be completed by previous Base Hospital

List of directives/medications:	PCP	ACP	List of directives/medications:	PCP	ACP
Continuous Positive Airway Pressure	☐	☐	Adult Intraosseous Access		☐
Electronic Control Device Probe Removal	☐	☐	Central Venous Access Device		☐
Nausea and Vomiting	☐	☐	Cricothyrotomy		☐
Supraglottic Airway	☐	☐	Nasotracheal Intubation		☐
PCP IV Access and Fluid Admin	☐		Procedural Sedation		☐
Cardiogenic Shock	☐		Amiodarone		☐
Manual Defibrillation	☐		Fentanyl		☐
Special Event (Headache, Minor Abrasion, Minor Allergic Reaction, Musculoskeletal Pain)	☐	☐	Ketamine		☐
Symptomatic Riot Agent Exposure (Chemical Exposure Medical Directive)	☐	☐	Lidocaine		☐
Hydrofluoric Acid Exposure (Chemical Exposure Medical Directive)	☐	☐	COVID-19	☐	☐
Adult Nerve Agent Exposure (Chemical Exposure Medical Directive)	☐	☐	Other: (pilots/research projects/ novel medical directive)	☐	☐
Pediatric Nerve Agent Exposure (Chemical Exposure Medical Directive)	☐	☐	Other:	☐	☐
Cyanide Exposure (Chemical Exposure Medical Directive)	☐	☐	**ALS PCS Version:**		

PART E: CONSOLIDATION

Is this Paramedic fully certified (i.e. has completed consolidation)?

☐ Yes
☐ No

Comments: _____

PART F: OTHER COMMENTS

To be completed by previous Base Hospital

PART G: BASE HOSPITAL CONFIRMATION

To be completed by previous Base Hospital

Name:

Title:

Email:

Signature:

Date: