



Continuing Medical Education - News & Information

March 2011 - Volume 17, Issue 3

Multi-Agency Edition

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(bold = new content)

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Journal CME Newsletter

Published monthly

FDNY - Office of
Medical Affairs

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Brooklyn, NY 11201

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From the Editor

**** 2011 REMAC Protocol revisions take effect July 1 ****

Although normally scheduled for April 1, this year's NYC REMAC protocol update has been changed for July 1 implementation in the field and on certification exams.

Until July 1, only the 2010 protocols are in effect.

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. On successfully completing a REMAC exam, candidates will receive a temporary letter verifying certification. They will soon after be mailed a memo directly from NYC REMSCO requiring a completed application, proof of NY State paramedic certification, 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

Effective April 1, 2010, NYC REMAC protocol revisions are to be implemented by paramedics updated by their Medical Director.

Per REMAC, ambulance services in NYC are responsible to provide copies of the protocols to their personnel. REMAC Advisories and Protocols are available to all at www.nycremsco.org

After April 1, only the April 2010 protocols may be used in the field and on NYC REMAC exams.

Questions may be referred to the REMAC Liaison at swansoc@fdny.nyc.gov or 718-999-2671.

Outline of April 2010 NYC REMAC protocol changes

see REMAC Advisory 2010-01 at nycremsco.org:

General Operating Procedures

- Oxygen Admin: removes respiratory rate as criterion for ventilation; removes mouth-to-mouth & mouth-to-nose ventilation
- Prehospital sedation: adds etomidate for cardioversion and pacing
- Communication with Medical Control: removes 20 minute on-scene time limit

BLS Protocols

- 401 Resp Distress: removes respiratory rate as criterion for ventilation; removes mouth-to-mouth & mouth-to-nose ventilation
- 407 Wheezing: adds epinephrine under Standing Orders with repeat Medical Control Option
- 410 Anaphylaxis: changes initial epinephrine dose to Standing Orders
- 421 Head & Spine Injuries: clarifies criteria for immobilization
- 423 Chest Injuries: removes bulky dressings for flail segments
- 425 Bone & Joint Injuries: note to request ALS for pain management; clarifies traction splint for closed injuries
- 428 Burns: note to request ALS for pain management; clarifies bandaging by BSA
- 430 EDP: note to request ALS for sedation
- 431 Heat-related Emergencies: removes saline PO

ALS Protocols

- 500-A Smoke Inhalation & 500-B Cyanide Exposure: clarifies sodium thiosulfate preparation
- 502 Obstructed Airway: removes needle cricothyroidotomy; adds procedure for right-mainstem bronchus displacement
- 503 Non-traumatic Arrest: removes reference to paddles
- 503-A V-fib/V-tach: changes joule setting
- 503-B PEA/Asystole: adds dextrose administration
- 504 Suspected MI: adds prompt OLMC contact; changes transport prior to IV admin
- 505-A, B & C Dysrhythmias: removes biphasic
- 505-D Brady Dysrhythmias: removes epi drip
- 506 APE: changes furosemide to Medical Control Option
- 510 Anaphylaxis: removes epi drip
- 521 Head Injuries: clarifies use of hyperventilation
- 540 Severe Pre-Eclampsia/Eclampsia: renames protocol; removes treatment for post-partum hemorrhage
- 551 Peds Obstructed Airway: removes needle cricothyroidotomy; adds procedure for right-mainstem bronchus displacement
- 554 Peds Asthma: clarifies ipratropium use
- 555 Peds Anaphylaxis: removes epi drip

Appendices

Appendix N Needle Cricothyroidotomy: deleted

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:

- | | |
|------------------|-----------------------|
| 15% Protocol GOP | 40% Adult Med. Emerg. |
| 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*
 - *Clinical rotations*
 - *Associated Certifications:
BCLS / ACLS / PALS / NALS / PHTLS*

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.

REMAC Quarterly Written and Oral examinations are held every January, April, July & October. Registration is limited to the first 50 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

REMSCO: www.NYCREMSCO.org
NYS/DOH: www.Health.State.NY.US

Online CME: www.EMS-CE.com www.MedicEd.com
www.EMCert.com www.WebCME.com
www.EMINET.com

FDNY ALS Division Coordinators

- Citywide ALS 718-999-1738
Lt. Joseph Pataky
 - Division 1 212-964-4518
Michael Matonis
 - Division 2 718-829-6069
Edwin Martinez
 - Division 3 718-968-9750
Gary Simmonds
 - Division 4 718-281-3392
Mike Romps
 - Division 5 718-979-7175
Joseph Farrell
 - Bureau of Training 718-281-8325
Hector Arroyo
 - EMS Pharmacy 718-571-7620
Cindy Corcoran
-

FDNY EMS -Division Medical Directors

- Dr. Dario Gonzalez 718-281-8473
Field Response Division 2
USAR/FEMA/OEM/HAZMAT Director
 - Dr. Glenn Asaeda 718-999-2666
Field Response Divisions 3 & 5
On-line Medical Control Director
USAR/ FEMA/OEM/HAZMAT Assoc. Director
REMSCO/REMAC Coordinator
 - Dr. Bradley Kaufman 718-999-1872
Field Response Division 4
System-wide Quality Assurance Director
Medical Director of EMD & PASU
 - Dr. John Freese 718-281-3861
Chief Medical Director
Director of Prehospital Research
 - Dr. Doug Isaacs 718-281-8428
Field Response Division 1
Medical Director of EMS Training
 - EMS Fellows
 - Dr. Angus Jameson 718-999-0351
 - Dr. Jessica Van Voorhees 718-999-0364
-

FDNY OLMC Physicians and ID Numbers

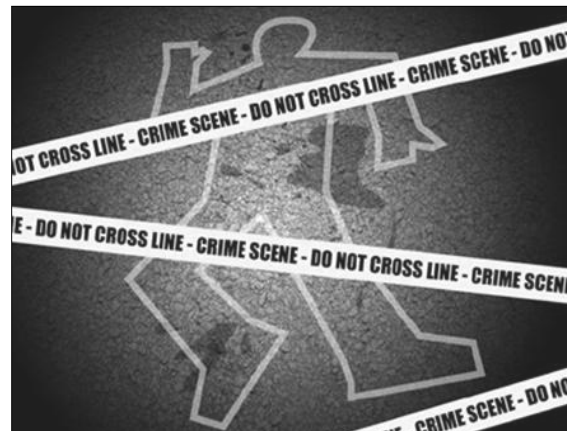
Alexandrou, Nikolaos	80282	Isaacs, Doug	80299
Asaeda, Glenn	80276	Jacobowitz, Susan	80297
Barbara, Paul	80306	Jameson, Angus	80309
Ben-Eli, David	80298	Kaufman, Bradley	80289
Cox, Lincoln	80305	Munjal, Kevin	80308
Freese, John	80293	Schenker, Josef	80296
Giordano, Lorraine	80243	Schneitzer, Leila	80241
Gonzalez, Dario	80256	Schoenwetter, David	80304
Hansard, Paul	80226	Silverman, Lewis	80249
Hegde, Hradaya	80262	Soloff, Lewis	80302
Hew, Phillip	80267	Van Voorhees, Jessica	80310
Huie, Frederick	80300		

March 2011 Journal CME Article

CRIME SCENE MANAGEMENT

I. INTRODUCTION

Unfortunately, a significant percentage of our trauma patients are intentionally injured. In addition to shootings and stabbings, patients may be victims of assaults with fists or blunt objects, sexual assaults, strangulations, or intentional vehicle collisions. Even motor vehicle accidents are considered a crime scene if one of the drivers is thought to be under the influence of alcohol or other intoxicants or had been found to be driving recklessly. In addition to managing these patients, EMS personnel also have to interact with law enforcement personnel. Although both groups share the goal of preserving life, we occasionally find our duties at a crime scene coming into conflict. Law enforcement officials, who maintain authority at a crime scene, are concerned about preserving evidence or bringing a perpetrator to justice while the primary focus for EMS providers is assessing a victim (or perpetrator) for signs of life or viability and providing emergency medical care. When operating at crime scenes, as we so often do, we must bear in mind these parallel goals and do our best to preserve evidence when possible. Patient care should never be compromised in order to protect a crime scene or evidence. Instead, as challenging as it may be, excellent patient care should be provided while trying to best preserve evidence.



II. CRIME SCENE OPERATIONS

Strategies to ensure crime scene preservation include having all personnel use a single path upon entering and leaving the scene, limiting the number of personnel entering the scene, and having all non-essential personnel remain outside the crime scene until their assistance is needed. Police investigators believe that everyone who enters a crime scene brings some type of evidence to the scene and unknowingly removes some evidence from the scene. Proper handling of a patient's clothing may preserve valuable evidence. If possible avoid cutting through cloth damaged by bullet or knife wounds. If available, place the clothing in a paper bag instead of a plastic bag.

If a patient has obvious signs of death (mortal injury, severe dependent lividity, rigor-mortis) refrain further moving or disturbing of the body. A hanging body should not be cut down or a bound victim untied. If care had been initiated and terminated at the scene, as it is our current policy, all expendable patient care equipment (e.g. ET tubes, IV lines, defibrillator pads) must be left in place. Do not further disturb the scene such as using the sink, telephone (unless an emergency) or removing any items (e.g. bullet casings).

Proper documentation, as it should always be, is extremely important. If a case goes to trial you will be called to testify on your role at the crime scene. EMS providers are not pathologists or forensics specialists. You will be questioned on what you observed and the patient care you provided. Remember, if it was not documented then it can be claimed that it never happened. The documentation must be legible, accurate, and concise. Only facts should be documented and not the

“truths” as you perceive them. For example, a fact would be that a patient has an altered mental status whereas a “truth” would be that the patient was under the influence of a chemical substance. It could be that they suffered a traumatic brain injury that made them appear to be under the influence of a chemical substance. The position of the patient should be noted, and record in detail any wounds including the number, location, size, shape, color, and any other characteristics. Do not give opinions such as “entry” or “exit” wounds (to be further discussed below). In addition, record any procedures including attempts and location.

Forensic evidence is the application of science and medical knowledge in determining the cause of an injury and/or death in a victim of crime. Television programs such as CSI have brought this specialty to the forefront. If life only imitated art, and if only it were that simple, to be able to solve multiple cases within an hour’s time-frame (including commercials)!



Determining the cause of death is difficult enough, but attempting to preserve and collect medical evidence while providing patient care can be extremely challenging. Forensic medicine, in cases of death, is necessary to determine the cause of death (gunshot wounds, stabbings, accidents, suicides, homicides), as well as time of injury to time of death. Many parties and agencies are interested in this information – law enforcement officials, family members, prosecutors, insurance companies.

The collection of medical evidence is vital in forensic medicine to help in determining the cause of death, injury, or assault. Was the injury self inflicted or caused by another? Was the alleged perpetrator right-handed or left-handed? Was there one assailant or multiple assailants? Was the patient shot from close range or from a distance? Was this a suicide or a homicide? These are just some of the questions that forensic medicine specialists may be able to answer based on forensic medical evidence.

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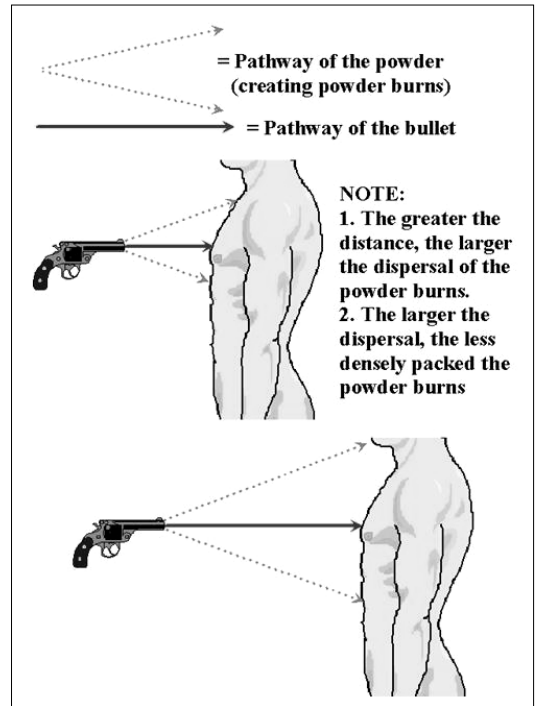
Our primary goal and role in pre-hospital care is to provide the best possible medical care in any given circumstance. We are taught to “not disrupt and disturb the ‘crime scene’ too much.” While we must always focus on our primary objective, it is important to be aware of law enforcement’s concerns and do our best to assist them in meeting their objectives. What we do at a crime scene may have a tremendous outcome on what ultimately happens to the patient and beyond.

III. INJURY PATTERNS

1. Gunshot Wounds

It is estimated in the literature that there are approximately 250,000 cases of gunshot wounds in the United States annually. When providing care for these victims of penetrating trauma, we should carefully document the number and location of wounds. In the past, it has been taught that entrance wounds are smaller than exit wounds, but more recently, the literature has reported that this may no longer be accurate. In truth, it is often extremely difficult to determine entrance versus exit. Because of this, we should document just the location and number of wounds, and leave determinations of direction of the projectile to forensic medical specialists.

Wound ballistics is essentially the effects of a projectile striking and penetrating the body. These effects are determined by the shape, size, and weight of a bullet. Its velocity, deformation capability upon tissue impact, path through the body, and final resting place also determine the effects of the projectile on the body. The distance from which the weapon was fired similarly plays a role in the type of injuries caused. For example, a contact wound where the weapon is fired at close range, essentially in contact with the body surface, will have different characteristics such as blackened wound edges from the soot of the discharge or a stellate or triangular shaped laceration. A more intermediate distance gun shot wound may have “tattooing” or “stippling” due to unburned gunpowder imbedding in the skin. Long distance wounds may have an “abrasion collar” which indicates that the injury was caused by the penetration of the bullet and not by thermal changes due to closer ranges.



2. Blunt Traumatic Injuries

Blunt trauma may cause abrasions, lacerations, or contusions outwardly visible when examining the skin. Obviously, there may be further internal injuries such as bony involvement not visible on external examination. Intra-abdominal and other internal injuries may not be evident immediately, and patients may later develop signs of hypovolemia and shock. All visible injuries should be documented appropriately and treated accordingly – direct pressure for any bleeding sites, immobilization for any suspected fracture sites. Often times, there may be “bite” marks as well evident on the skin, which should also be treated and documented accordingly. From the forensic medicine perspective, these injuries may be important. Was this “bite” from an animal or from a human? If human, was it from an adult or from a child?

3. Sharp Force Trauma

There are essentially two classes of sharp force injuries – incised (where there is a drawing motion causing longer wounds rather than deep) and stabbed (puncture type of injury that usually is deeper than wide). Sharp force injury wounds tend to be “cleaner” than blunt force injuries which tend to produce more “jagged” wounds. Depending on the type of wound observed, from the forensic medicine perspective, the type of weapon may be determined. For example, a single penetrating circular wound may indicate an ice pick. From our pre-hospital perspective, all penetrating wounds should be treated appropriately and accurate documentation should be conducted as always.

IV. SPECIAL CIRCUMSTANCES

1. Sexual Assault

All 911 receiving emergency departments are able to provide appropriate general medical care to any patient that walks into their emergency department. However, since 2008 one category of specialty referral facilities, the Sexual Assault Forensic Examiner (SAFE) Program sites, is better able to manage these victims of crime. Not only do SAFE centers have better resources to provide appropriate medical care for sexual assault victims, in addition they have specially trained teams that include physicians, nurses and social workers to help the patients through this emotionally traumatic time. The medical

teams are specifically trained in collecting forensic evidence, such as DNA samples and are often called in to court to provide testimony at time of trial. When evidence is collected improperly, advanced forensic techniques such as DNA analysis leading to the successful prosecution of a perpetrator may not be able to be employed. It is unfortunate that all too often evidence can be thrown out of court due to the improper collection of evidence, and we should make use of SAFE centers to care for these patients and appropriately collect evidence whenever possible.

From the pre-hospital perspective, providers should identify any life threats and treat and transport accordingly (trauma center if those criteria are met), or encourage transport to emergency departments with SAFE Programs if the patient is deemed to be stable. As with all other cases, appropriate treatment per protocols should be provided and accurate and appropriate documentation should be conducted. As of the writing of this article, there are 19 such identified emergency departments with SAFE Programs throughout the 5 Boroughs. These facilities allow for expert medical management, collection of evidence and testimony through the 24-hour availability of trained sexual assault examiners, specialized equipment to detect and document injury, dedicated examination and shower rooms, trained advocates and full-time social workers for follow-up counseling services and emotional support.

2. Strangulation

Strangulation is a form of asphyxia (lack of oxygen) characterized by the closure of blood vessels and/or air passages of the neck as a result of external pressure on the neck. It can induce loss of consciousness within seconds and death within minutes. Although there is a technical difference between choking (obstruction of an airway) and strangulation, these terms are often used interchangeably in cases of domestic violence and assault.

On November 11, 2010, New York State Penal Law 10.00(9) for assault was amended to add Article 121, which specifically addressed strangulation as a separate crime under assault. Until this change, strangulation in and of itself was not considered a crime and had to be attached to an assault charge, which made prosecution extremely difficult. With this change, law enforcement officials and prosecutors can now bring charges upon assailants solely on this act. This means that our pre-hospital documentation becomes even so much more important when these potential cases go to trial. As with any other injuries, appropriate treatment and documentation must take place.

Unfortunately, the signs and symptoms of strangulation may often be subtle; they are varied and may include those listed in Table 1. It is important to note that there may not be a report of strangulation or assault due to embarrassment or the intense emotions associated with domestic violence situations. Pre-hospital care providers must be vigilant for these potential clues to strangulation and maintain a high index of suspicion.

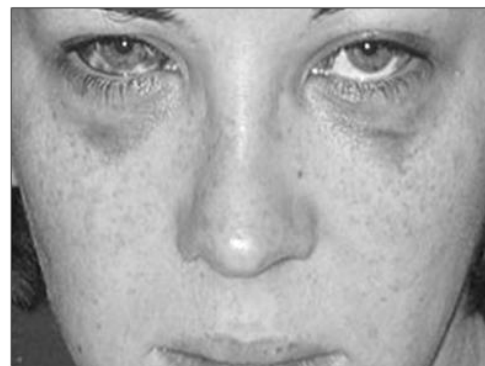


Table 1.

SIGNS AND SYMPTOMS OF STRANGULATION
<i>Difficulty breathing</i>
<i>Hyperventilation</i>
<i>Raspy or hoarse voice</i>
<i>Difficulty swallowing</i>
<i>Drooling</i>
<i>Scratches or redness on the neck</i>
<i>Flushing of the face</i>
<i>Bloody conjunctiva (Petechial Hemorrhages)</i>
<i>Epistaxis</i>
<i>Lightheadedness</i>
<i>Loss of consciousness</i>

V. CONCLUSION

Whenever trauma is discussed, forensic medicine should also be touched upon. Our primary goal is to provide the highest level of medical care possible. However, it is clear that our patient care documentation will often become crucial from the forensic medicine perspective. Many of you will be called upon to testify as to what you observed and what you documented as you treated your patients. In the pre-hospital realm, we may often be limited as to what we may document due to the inability to make definitive diagnoses without additional testing. Trying to preserve forensic evidence while providing medical care can be extremely challenging. As long as each member adheres to treatment protocols, crime scene operation SOG's, and standard documentation strategies, you should be able to meet any challenge from the forensic medicine perspective.

Written by:

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FDNY Medical Director
EMS Bureau of Training

GLENN ASAEDA, MD
FDNY Medical Director
EMS Division 3 and 5

CME JOURNAL 2011_J0 03: CRIME SCENE MANAGEMENT QUIZ

- All of the following techniques should be utilized at a crime scene except:***
 - having all personnel use a single path upon entry and leaving the scene
 - only allowing the highest ranking EMS officer on scene
 - limiting the number of personnel entering the scene
 - having all non-essential personnel remain outside the crime scene until their assistance is needed
- If available, any clothing from a crime should be placed into:***
 - plastic bags
 - paper bags

3. *If care has been initiated and terminated at the scene, current policy dictates that the following equipment be left in place:*
- A. ET tubes
 - B. IV lines
 - C. Defibrillation pads
 - D. All of the above
4. *Patient documentation should be all of the following except:*
- A. legible
 - B. accurate
 - C. concise
 - D. written in blue ink
5. *Only _____ should be documented and not the _____.*
- A. facts, “truths” as you perceive them
 - B. “truths” as you perceive them, facts
6. *Forensic Medicine is:*
- A. the facts and “truths” as you perceive them at a crime scene
 - B. the science of lawyers prosecuting civil cases
 - C. the application of science and medical knowledge in determining the cause of an injury and/or death in a victim of crime
 - D. random guessing through trial and error
7. *Our primary goal as pre-hospital care providers at a crime scene is:*
- A. to defer to law enforcement officials as to patient care
 - B. to preserve evidence first
 - C. to provide the best possible medical care
 - D. to document events leading up to the injury
8. *Which of the following is not considered a class of sharp force injury?*
- A. incised
 - B. lacerated
 - C. stabbed
9. *SAFE Centers provide all of the following except:*
- A. expert medical management by trained sexual assault examiners
 - B. expert collection of evidence and testimony
 - C. 24 hour home security services
 - D. trained advocates and full time social workers for follow up counseling services and emotional support
10. *All of the following are signs and symptoms of strangulation except:*
- A. difficulty breathing
 - B. raspy or hoarse voice
 - C. drooling
 - D. flushing of the abdomen
 - E. flushing of the face

Journal CME Credit Answer Sheet

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 this month.

March 2011 CME Quiz		
1.		Required for BLS & ALS providers
2.		
3.		
4.		
5.		
6.		Required for ALS providers only
7.		
8.		
9.		
10.		

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Citywide CME – March 2011

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

Boro	Facility	Date	Time	Topic	Location	Host	Contact
BK	Kingsbrook	TBA	TBA	TBA: call to inquire →	ED Conference Room	Dr Hew	Manny Delgado 718-363-6644
	LICH	TBA	TBA	TBA: call to inquire →	Avram Conference Room "G"	Dr Vlasica	Aaron Scharf 718-780-1859
	Lutheran	4 th Wed	1730-1930	Call Review RSVP →	Call for location →	Dr Chitnis	Dale Garcia 718-630-7230 dgarcia@lmcmc.com
MN	NY Presbyterian	3/28	1700-2100	Lectures: Cardiology, Sepsis RSVP →	Weill Cornell Campus A-950	Dr Ewy	RSVP: ssamuels@nyp.org Ana Doulis 212-746-0885 x2
	NYU School of Medicine	TBA	TBA	TBA: call to inquire →	Schwartz Lecture Hall 401 E 30 Street	TBA	Jessica Kovac 212-263-3293
QN	FDNY-BOT	Cancelled until further notice		---	---	---	---
	NYH Queens	Thursdays	0800-0900	Call Review/Trauma Rounds	East bldg, courtyard flr	Dr Sample	Mary Ellen Zimmermann RN 718-670-2929
	Mt Sinai Qns	last Tues	1800-2100	Lecture	25-10 30 Ave, conf room	Dr Dean	Donna Smith-Jordan 718-267-4390
	Parkway Hosp	3 rd Wed	1830-2130	Call Review	Board Room, 1st flr		pabruzzino@capitolhealthmgmt.com
	Queens Hosp	2 nd Thurs 4 th Thurs	1615-1815	Call Review	Emergency Dept		718-883-3070
SI	RUMC	3/3	1400	Call Review	MLB conf room	Dr Ben-Eli	William Amaniera 718-818-1364
		4/5	1100	Call Review/Protocol Update	SIPP auditorium		
		5/5	1400	Call Review/Protocol Update	MLB conf room		

2011 NYC REMAC Examination Schedule

Month	<u>REMAC Refresher Exam</u> (Written only - CME letter required)		<u>REMAC Quarterly Exam - \$100 fee</u> (Written & 3 Orals Scenarios)			NYS/DOH Written Exam
	Registration Deadline	Exam Date (on Wednesdays)	Registration Deadline	Written @18:00	Orals @09:00	
January	12/31/10	1/19/11	Thursday 1/6/11	Thursday 1/20/11	Thursday 1/27/11	1/20/11
February	1/31/11	2/23/11				
March	2/28/11	3/23/11				3/24/11
April	3/31/11	4/20/11	Thursday 4/7/11	Thursday 4/21/11	Tuesday 4/26/11	
May	4/30/11	5/25/11				5/20/11
June	5/31/11	6/22/11				6/16/11
July	6/30/11	7/20/11	Thursday 7/7/11	Thursday 7/21/11	Thursday 7/28/11	
August	7/31/11	8/24/11				8/18/11
September	8/31/11	9/21/11				
October	9/30/11	10/26/11	Thursday 10/6/11	Thursday 10/20/11	Tuesday 10/25/11	
November	10/31/11	11/16/11				11/17/11
December	11/30/11	12/21/11				12/15/11

The **REMAC Refresher Written examination** is offered monthly for paramedics who meet CME requirements **and** whose REMAC certifications are either current or expired **less** than 30 days. To enroll, call **718-999-7074** before the register registration deadline above. Candidates may attend an exam no more than 6 months prior to expiration. Refresher exams are held at 07:00 or 18:00 hours at FDNY-EMS Bureau of Training, Fort Totten, Queens.

The **REMAC Quarterly Written & Orals examination** is for initial certification, **or** for inadequate CME, **or** for certifications expired **more** than 30 days. Registrations **must** be postmarked by the deadline above. Email swansoc@fdny.nyc.gov for instructions. You are encouraged to **register at least 30 days** prior to the exam - seating is limited. The exam fee as above is by **money order only**. The Quarterly is held at FDNY-EMS Bureau of Training, Fort Totten, Queens.