**September 1, 2016 REMAC Protocol revisions go into effect. See page 2 for details**

**From the Editor**

*New Journal Editor and NYC REMAC Liaison*

This month the FDNY Office of Medical Affairs bids farewell to this Journal’s editor, Paramedic Christopher Swanson. For thirty-two years, Chris served New York City with distinction as EMT, paramedic, instructor, and REMAC Liaison. He is retiring to his farm in North Carolina. We wish him well in his endeavors.

The new Journal editor and REMAC Liaison is Lt. Samuel Jimenez, who has worked in pre-hospital care in NYC for 8 years. Sam served in the United States Marine Corps in Iraq during Operation Iraqi Freedom. As he assists the paramedics of New York City with their certification needs, it is his goal to maintain the standards of professionalism and integrity exhibited by his predecessors. The staff of this Journal wishes him the best of luck.

**All candidates must now meet CME requirements**

- All REMAC paramedics and candidates should review Certification & CME Information on page 3 journal and plan accordingly.
- All upcoming exam candidates, see registration instructions at the bottom of the last page of this journal.

Candidates who will not have a CME letter at the time of their REMAC exam must email Samuel.Jimenez@fdny.nyc.gov ASAP.
** On September 1, 2016 REMAC Protocol revisions take effect for the field and exams **

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

Always see [nycremsco.org](http://nycremsco.org) for the current approved protocols

For updates, see REMAC Advisories 2016-02 & 2016-03 at nycremsco.org

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**General Operating Procedures**

- No changes

**BLS Protocols**

- 407 – Wheezing
  - Removes age limit for epinephrine

- 410 – Anaphylaxis
  - Removes age limit for epinephrine

- 421 – Head and Spine Injuries
  - Adds statement: hyperventilation not to be performed

**ALS Protocols**

- 506 – APE
  - Removes morphine sulfate

- 511 – AMS
  - Adds IN route for glucagon

- 513 – Seizures
  - Adds IN route for glucagon

- 528 – Burns
  - Changes fentanyl to Standing Order

- 529 – Pain Management
  - Changes fentanyl to Standing Order

- 550 – Peds Respiratory Arrest
  - Changes naloxone increments

- 556 – Peds AMS
  - Adds IN route for glucagon

- 557 – Peds Seizures
  - Adds IN route for glucagon
  - Removes rectal diazepam

- New protocol – Hyperglycemia

**Appendices**

- No changes
REMAC Exam Study Tips

REMAC candidates have difficulty with: REMAC Written exams are approximately:
* 12-lead EKG interpretation 10% BLS 15% Adult Trauma
* ventilation rates for peds & neonates 10% Adult Arrest 15% Pediatrics

Certification & CME Information

- By the day of their exam, all REMAC paramedics and candidates must present a letter from their Medical Director verifying fulfillment of CME requirements.

- Upcoming candidates without a CME letter ASAP must email Samuel.Jimenez@fdny.nyc.gov

- 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 # 2007-11:
  - 36 hours - Physician Directed Call Review
    - ACR Review
    - QA/I Session
    - Emergency Department Teaching Rounds - Maximum of 18 hours
  - 36 hours - Alternative Source CME - Maximum of 12 hours per venue
    - Online CME (see examples below) - Clinical rotations
    - Lectures / Symposiums / Conferences - Associated Certifications – 4 hours each:
      - BCLS / ACLS / PALS / NALS / PHTLS
    - Journal CME

- Failure to maintain a valid NYS EMT-P card will suspend your NYC REMAC certification until NYS is recertified.

REMACE certification exams are held monthly for new and expired candidates, and for currently certified paramedics who may attend up to 6 months before their expiration date.

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

FDNY ALS Division Coordinators

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Lt. Telina Lloyd Mike Romps

Division 1 212-964-4518 Division 5 718-979-7175
William Meringolo Krista O’Dea

Division 2 718-829-6069 Bureau of Training 718-281-8325
Michael Sullivan Hector Arroyo / Lisa Desena

Division 3 718-968-9750 EMS Pharmacy 718-571-7620
Gary Simmonds Cindy Corcoran

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OLMC Director USAR/FEMA Director, OEM Liaison

Dr. Glenn Asaeda 718-999-2790 Dr. Doug Isaacs 718-281-8428
Chief Medical Director Field Response Division 1
REMAC Coordinator EMS Fellowship & Rescue Medic Director

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Field Response Division 4 QA, EMD & EMS Training Director
Haz-Tac, PASU & EMS Resident Director

EMS Fellows - Field Response Division 5
Dr. Nathan Reisman 718-999-0364 Dr. Carolina Periera 718-999-0351

FDNY OLMC Physicians and ID Numbers

Alexandrou, Nikolaos 80282 Jacobowitz, Susan 80297
Asaeda, Glenn 80276 Kaufman, Bradley 80289
Barbara, Paul 80306 Lai, Pamela 80311
Bayley, Ryan 80314 Munjal, Kevin 80308
Ben-Eli, David 80298 Redlener, Michael 80312
Freese, John 80293 Rotkowitz, Louis 80317
Friedman, Matt 80313 Schenker, Josef 80296
Giordano, Lorraine 80243 Schneitzer, Leila 80241
Gonzalez, Dario 80256 Silverman, Lewis 80249
Hansard, Paul 80226 Soloff, Lewis 80302
Hegde, Hradaya 80262 Van Voorhees, Jessica 80310
Hew, Phillip 80267 Williams, Alan 80316
Huie, Frederick 80300 Zabar, Benjamin 80323
Isaacs, Doug 80299 Zimmerman, Jason 80324
For protocol updates, see REMAC Advisories 2016-02 & 2016-03 at www.nycremsco.org

REMAC Protocol Update

This CME Journal will serve as an educational update for the revised NYC Regional Emergency Medical Advisory Committee (REMAC) Protocols. Individual agencies may choose when to implement these changes between July 1, 2016 and September 1, 2016. This block of time allows individual agencies to coordinate the timeframe by which they update their providers. At the FDNY, the Journal CME must be completed by all providers by the end of August, and therefore we will go live with the revised protocols as an agency on September 1, 2016. Nevertheless, you must be aware that providers in other EMS agencies may be using the revised protocols after July 1. Even if you complete this CME Journal and quiz prior to September 1, you must continue to use the old protocols until September 1. Note that the naloxone dosing change in ALS protocol 550 is a correction, not a revision, and is effective immediately.

As you will see, there are not as many changes this year as in the past. The General Operating Procedures (GOPs) are unchanged. There are changes to three (3) BLS protocols and eight (8) ALS protocols, plus the addition of a new ALS protocol for the treatment of hyperglycemia.

Wheezing (BLS Protocol 407) and Anaphylactic Reaction (BLS Protocol 410)

The upper age limit of 33 for the use of epinephrine auto-injectors has been removed.

BLS administration of epinephrine via auto-injector is only used for life-threatening emergencies such as severe respiratory distress from wheezing or anaphylaxis. In such situations, the benefit of rapid epinephrine administration outweighs the risks of epinephrine use in the older population. BLS units encountering a patient of any age who meets the criteria in protocols 407 and 410 should administer epinephrine.

Head and Spine Injuries (BLS Protocol 421)

A note was added specifying that hyperventilation should not be performed.

Hyperventilation has been used in the past in an attempt to decrease intracranial pressure (ICP) in head-injured patients. Recent evidence suggests that head-injured patients who receive hyperventilation may have worse outcomes, and that hyperventilation is not very effective at lowering ICP. Hyperventilation is no longer recommended for any head-injured patients and should not be performed.
Acute Pulmonary Edema (ALS Protocol 506)

*Morphine was removed* as a treatment option for acute pulmonary edema.

Although morphine has been a standard therapy for acute pulmonary edema (APE) for many years, large studies have shown that patients who are given morphine for pulmonary edema are more likely to do poorly during their hospital stay and have an increased mortality. Morphine is no longer used routinely for the treatment of APE. If patients with pulmonary edema are anxious or unable to tolerate therapies, medical control should be contacted for orders to administer benzodiazepines. Morphine will no longer be given to patients with APE.

Altered Mental Status (ALS Protocol 511), Seizures (ALS Protocol 513), Pediatric Altered Mental Status (ALS Protocol 556), and Pediatric Seizures (ALS Protocol 557)

The *intranasal (IN) route has been added* for glucagon administration.

Glucagon stimulates the conversion of glycogen into glucose, but may be ineffective in patients with inadequate glycogen stores, such as patients with chronic illness or frequent episodes of hypoglycemia. If IV access is available, intravenous dextrose is preferred over glucagon. If IV access is unobtainable, glucagon may be administered through either the intramuscular or the intranasal routes.

In addition to the above, there is one other change to the Pediatric Seizures protocol (Protocol 557). *Medical Control Option C has been deleted.*

The rectal route for administration of diazepam has significant limitations in the prehospital setting. Pediatric patients with ongoing or recurring seizures who do not have IV access should be treated with intramuscular or intranasal benzodiazepines.

Burns (ALS Protocol 528) and Pain Management for Isolated Extremity Injury (ALS Protocol 529)

*Fentanyl has been moved from being a Medical Control Option to a Standing Order.*

*Note that these protocols apply to both adult and pediatric patients.*

Fentanyl is a synthetic opioid that is many times more potent than morphine. While morphine directly activates mast cells, causing a release of histamine, fentanyl does not. Histamine causes an itchy skin rash and can cause systemic vasodilation leading to hypotension. Although fentanyl does not directly cause vasodilation or hypotension, some decrease in blood pressure may be seen due to a decrease in adrenergic tone when pain relief is achieved. The onset of action for fentanyl is almost immediate via the IV route, and within 5-10 minutes via the IN or IM routes. Peak effect is also very quick at 5-10 minutes, while morphine’s peak effect is 15-90 minutes. Fentanyl’s effective half-life is about 30 minutes and re-dosing may be required for patients with extended extrication or transport times. OLMC must be contacted for all repeat doses of fentanyl. For patients meeting the pain control criteria in Protocols 528 or 529, Paramedics may choose either morphine or fentanyl at their discretion.

Hyperglycemia (New ALS Protocol)

*A new protocol for the management of hyperglycemia was created.*

Patients who are severely hyperglycemic are also profoundly dehydrated. The initial treatment for hyperglycemia is volume replacement with IV fluids. For all patients with severe hyperglycemia, fluid administration should be started. Large volumes of IV fluid must be given with caution to patients with heart or renal failure, and frequent reassessment of respiratory status is required.
Pediatric Respiratory Arrest (ALS Protocol 550)

The dose of naloxone has been corrected.

For pediatric patients in respiratory arrest, naloxone should be administered in increments of 0.5 mg, up to a total of 2 mg, titrated to response. Naloxone may be given intramuscularly; transport should not be delayed to obtain IV access.

Since naloxone may precipitate withdrawal symptoms, the smallest dose needed should be used. Titration is the administration of incremental doses of a drug until a desired effect is reached. It is important to observe the patient response before delivering the next dose. The desired effect for administration of naloxone should be to counteract opioid associated respiratory depression until spontaneous ventilations are adequate and do not require assistance. Naloxone should never be used to awaken comatose patients or improve mental status in patients with adequate respiratory effort. Assess respirations for rate and effort. Snoring respirations may be corrected with repositioning of the airway.

Conclusion

The Regional EMS Medical Advisory Committee is continually working to advance the care of patients in the prehospital setting. Innovations in the field of emergency medicine and EMS care can be brought to the patient in a consistent and uniform way through the process of protocol development and periodic updates. This ultimately becomes part of the working professional standard of care for EMS, allowing the region to stay current with the latest prehospital medical treatment. The following pages contain the REMAC advisories with the exact wording of the protocol changes.

Written by: Nathan Reisman, Bradley Kaufman, MD, Lt. Joan Hillgardner
FDNY EMS Fellow, First Deputy Medical Director, FDNY Office of Medical Affairs
1. A 43 year-old female was struck by a bus and sustained a head injury. Upon initial assessment, she is comatose and apneic. Bystanders report seeing seizure activity after the accident. Her heart rate is 128 bpm, BP is 172/69 mmHg, and GCS is 3. How should the airway be managed?
   a. Maintain an open airway with head tilt and chin lift
   b. Place an oropharyngeal airway if patient does not have gag reflex
   c. Hyperventilate at a rate of 14-18 breaths per minute
   d. Hyperventilate only if the patient remains unresponsive

2. A BLS crew encounters a 77 year-old male in a seafood restaurant in respiratory distress. The family reports that he mistakenly ate a shrimp dish, for which he has an allergy. He is in severe respiratory distress, breathing at 36 times per minute with marked stridor. His heart rate is 120 bpm and BP is 90/58mmHg. He does not have a prescribed epi-pen. What is the best treatment?
   a. Contact OLMC for orders to administer epinephrine
   b. Request ALS assistance immediately and await their arrival
   c. Administer epinephrine via auto-injector
   d. Initiate immediate transport and do not administer epinephrine

3. A 22 year-old male was a seat belted driver in a vehicle that was rear-ended. He is complaining of lower extremity tingling sensation. A rigid cervical collar should be applied.
   a. True
   b. False

4. You are caring for a 10 year-old female patient complaining of an asthma exacerbation. Her respiratory rate is 22 breaths per minute, able to speak in full sentences, and noted to have expiratory wheezes in bilateral lung fields. What treatment is indicated?
   a. Administer adult epinephrine auto-injector
   b. Administer pediatric epinephrine auto-injector
   c. Administer albuterol via nebulizer
   d. Contact medical control for authorization to administer epinephrine auto-injector

5. The protocol changes reviewed in the CME Journal do not go into effect for FDNY providers until September 1, 2016.
   a. True
   b. False
6. A 69 year-old female patient with history of CHF is complaining of shortness of breath. An ALS unit arrives on-scene and assesses the patient. She is hypertensive and tachycardic, and the paramedics recognize pulmonary edema. She is started on nitrates and oxygen, and CPAP is attempted. The patient is alert and oriented, but very anxious and unable to tolerate the mask. What is the next step?

   a. Perform immediate endotracheal intubation  
   b. Administer intravenous morphine  
   c. Contact OLMC for orders to administer intravenous morphine  
   d. Contact OLMC for orders to administer intravenous midazolam

7. A 50 year-old male is found at home with altered mental status. He is diabetic and has poorly controlled blood sugar resulting in frequent episodes of both hyperglycemia and hypoglycemia. He is alert but disoriented. The initial attempt at intravenous access fails. Which is the next best option?

   a. Administer dextrose solution IM  
   b. Administer glucagon IN  
   c. Make further attempts to obtain IV access and administer glucagon IV  
   d. Place an IO line and administer a dextrose solution

8. A 32 year-old bakery worker is encountered after having his hand stuck inside a commercial grinder. He has sustained major injuries to his hand and wrist, with multiple deformities and lacerations. There are no other injuries. His vital signs are: HR: 120/min; BP 102/78 mmHg; RR: 20/min; GCS: 15. He is complaining of severe pain to the injured hand. After bleeding is controlled, what is the next step?

   a. Administer morphine  
   b. Administer fentanyl  
   c. Administer low-dose ketamine  
   d. Contact OLMC for discretionary orders

9. A 72 year-old male with history of CHF and diabetes is complaining of general malaise and generalized weakness. On initial assessment, the following vitals are obtained: HR: 104/min; BP: 155/72 mmHg; RR 26/min; O₂ saturation: 98% on room air. He is alert and oriented. His blood glucose level is 525 mg/dL. What is the correct management?

   a. Immediately administer 2 liters of intravenous sodium chloride  
   b. Assess and monitor respiratory status, and begin IV fluids as long as his lungs remain clear  
   c. Do not administer IV fluids to a patient with a history of CHF  
   d. Administer subcutaneous insulin

10. An 11 year-old girl presents with respiratory arrest. She is unconscious and apneic. The etiology of her symptoms is unknown. The patient is unable to be intubated and immediate transport is initiated. Which medications should be administered while en route to the hospital?

    a. Naloxone 2 mg IV  
    b. Naloxone 2 mg IM 
    c. Naloxone IM, titrated in increments of 0.8 mg, up to response, up to 2 mg  
    d. Naloxone IM, titrated in increments of 0.5 mg, up to response, up to 2 mg
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 August 2016

July - August 2016 CME Quiz

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for BLS providers

for ALS providers

July – August 2016 – Journal CME Newsletter
Regional CME – Sessions are subject to change. Please confirm through the listed contact.

See other opportunities at [www.nycremsco.org](http://www.nycremsco.org) under News & Announcements

**Note:** A potential source of Call Review is **E.D. Teaching Rounds** (maximum of 18 hours)

See any hospital E.D. Administrator for availability (especially HHC hospitals)

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<td>Call Review, Trauma Rounds</td>
<td>A1-22 Auditorium 3rd Wednesdays, 0830-0930</td>
<td>Anju Galer RN 718-334-5724 <a href="mailto:galera@nychhc.org">galera@nychhc.org</a></td>
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<td>Mt Sinai Qns</td>
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<td>25-10 30 Ave, conf room last Tuesdays, 1800-2100</td>
<td>Donna Smith-Jordon 718-267-4390</td>
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<td>contact to inquire →</td>
<td>East bldg, courtyard flr</td>
<td>Mary Ellen Zimmermann RN 718-670-2929</td>
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<td>Queens Hosp</td>
<td>Call Review</td>
<td>Emergency Dept 2nd &amp; 4th Thurs 1615-1815</td>
<td>Maria Jones or Julia Fuzailov 718-883-3070</td>
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<td>St John’s University</td>
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<td>175-05 Horace Harding Expwy</td>
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<td>1st floor Board Room</td>
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1 REMAC Refresher 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.

2 REMAC Basic 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 by $100 money order to NYC REMSCO is required.

All Basic candidates must meet new education requirements. Email Samuel.Jimenez@fdny.nyc.gov for instructions.

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