Loyola Emergency Medical Services System *Record of Continuing Education*

Provider Information				
Loyola System Number		*Name*		
Provider Level: ☐ First Responder ☐ EMT-B ☐ EMT-P ☐ PHRN ☐ ECRN ☐ EMD ☐ Other				
Monthly Continuing Education				
Date	*Lecture Topic – Month/Year*	*Test Topic– Month/Year*	*Pass/Fail*	*Hours*
Specialty Course / Outside System Continuing Education *				
Course / Lecture Topic			*Date*	
Location		*Site Code #*	*Credit Hours*	
** Attach copy of certificate if issued*				
Clinical Rotation				
Clinical Area			*Date*	
Preceptor		*Time In-Out*	*Total Hours*	
Describe a principle learned and how it will effect your practice:				
Course Instructor/Clinical Preceptor Signature ____________________ *Date* __________				
The above information is complete and accurate in accordance with the policies and procedures of the Loyola Emergency Medical Services System. *Provider Signature* ____________________ *Date* __________				

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