Government of Newfoundland and Labrador
Department of Health and Community Services
Newfoundland and Labrador Paramedicine Regulation (NLPR)

CME REPORTING – TRAINING WITHOUT CERTIFICATES

Please use a laptop or personal computer containing Adobe software to complete the form electronically to NLPR. Phones or handheld devices may have software incompatibility. Photographs of documentation are not accepted.
Reporting forms must accompany all requests for CME credit.

STEP ONE - CME INFORMATION *(please complete one form per each CME item)*

Title of CME: _____

Requested CME Hours: _____ Location *(if necessary)*: _____ Date Completed: _____
(DD-MONTH-YYYY)

Learning Outcomes: _____
_____

Key Category: _____
(For multiple Key Categories please itemize a list separately)

Detailed Resource Information Used:
(website; title; books/magazines including page numbers: etc.)
_____
_____

To show a course is medically relevant to Paramedicine a competency overview from the provider may be required for submission showing how the course meets specific competencies as outlined in the National Occupational Competency Profiles (NOCP):

National Occupational Competency Profiles (NOCP)

STEP TWO - CME GROUP *(check the appropriate group for each CME item)*

☐ Training Courses without Certificate

A Facilitator signature is necessary for sessions/courses when completion certificates are not issued.
COURSE OUTLINES OR AGENDAS MUST ALSO BE PROVIDED.

Facilitator Name: _____ Agency: _____

Facilitator Signature: _____ Date: _____
(DD-MONTH-YYYY)

Phone: _____ Email: _____

☐ Self-Research / Review

SYNOPSIS REPORTS MUST ALSO INCLUDE RESOURCE INFORMATION.
Reports must outline objectives learned after reading educational materials; professional practice articles; etc. including how it applies within the Paramedicine environment. CME hours are determined from both the synopsis report and overall content of resources information combined.

PROVIDER VERIFICATION

By signing this form as the provider, I attest all the information listed above to be true:

Provider Name: _____ NLPR #: _____

Provider Signature: _____ Date: _____
(DD-MONTH-YYYY)

NLPR USE ONLY

Evaluation of CME: _____ Total Hours: _____

☐ Approved Approval # _____ Received _____

☐ Not Approved Entered _____

Reviewed by: _____ Date: _____
(DD-MONTH-YYYY)