Newfoundland & Labrador

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

PROFESSIONAL PRACTICE HOURS REPORTING

Only Paramedicine providers within the NL Health Services (NLHS) Paramedicine program can use this form. All other providers require an Employment Verification Letter from their associated employer outlining professional practice hours, scope of practice, and job-related duties within the specified two-year term.

GENERAL PROVIDER INFOMATION

Provider Name: ______________________________ NLPR Licence #: ____________

NL Health Services (NLHS) Paramedicine Program

Regional Zone: ______________________ Site Location: ______________________

Professional Practice Position Category: *(Must be within the sphere of influence pertaining to Paramedicine)*

☐ Clinical ☐ Management/Administrative ☐ Teaching ☐ Dispatching ☐ Research ☐ Other

(Category definitions are outlined in NLPR Policy)

PROFESSIONAL PRACTICE INFORMATION *(To be completed by an authorized representative*)*

1.	Has the provider acquired practice hours within the NLHS Paramedicine program? *(If NO, an Employment Verification Letter is necessary to outline hours, scope of practice, and job-related duties)*	☐ Yes ☐ No
2.	If YES to Question #1, please confirm the scope of practice level associated with the position of the Paramedicine provider. *(CCP; ACP; PCP; EMR)*	________
3.	What is the specific two-year term associated with the Paramedicine provider? *(Two-year terms are outlined on the NLPR licence confirmation or ID card of the Paramedicine provider)* ☐ April 2024 - March 2026 ☐ April 2025 – March 2027	
4.	Has the provider met the minimum requirement of 600 Professional Practice Hours within the specified two-year term? *(Please DO NOT include postdated hours with this information)*	☐ Yes ☐ No
5.	If NO to Question #4, please confirm the number of Professional Practice Hours the provider has met <u>to date</u> within the specified two-year term.	________

**An authorized representative is a person in a management position for the NLHS Paramedicine program who can confirm the professional practice hours of the Paramedicine Provider.*

By signing below as the authorized representative, I attest all the information listed above to be true:

Name: ______________________________ Title: ______________________

Signature: ____________________________ Date: ______________________
(DD-MONTH-YYYY)

Phone: ________________ Email: ______________________________

NLPR USE ONLY

☐ Approved ☐ Not Approved

Reviewed by: ____________________________ Date: __________________
(DD-MONTH-YYYY)

Notes: ____