



PARAMEDIC PRECEPTOR RECOMMENDATION FORM

Paramedic Name:

NYS EMT #:

Agency:

Years as Paramedic:

MLREMS Clearance Date:

Note: If the individual being nominated does not meet the requirements for ALS Preceptor as outlined in the [Monroe-Livingston Regional ALS Preceptor Policy](#), this recommendation must be accompanied by a letter outlining the experience and/or additional training that this individual has in order to be considered for such a waiver and that letter must be signed by the Agency Medical Director.

- I affirm that the provider listed above meets all of the requirements for ALS Preceptor as outlined in the Monroe-Livingston Regional ALS Preceptor Policy.

- This provider does not meet all of the requirements for ALS Preceptor as outlined in the Monroe-Livingston Regional ALS Preceptor Policy. I am requesting a waiver of those requirements and have attached a letter signed by the Medical Director as required.

As Clinical Care Manager/Chief, I affirm that I and the Agency Medical Director support the nomination of this individual as a Paramedic Preceptor in the Monroe-Livingston Region. I forward this recommendation for REMAC Patient Safety Committee consideration on behalf of the agency listed above.

Clinical Care Manager/Chief Name:

Clinical Care Manager/Chief Email Address:

Date of Recommendation:

Upon completion, submit to mlrems@mlrems.org

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