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

Continuing Medical Education
Reporting - Training without Certificates

Please use either a laptop or personal computer in order to complete and submit this form electronically to NLPR. Phones or hand held devices may have software incompatibility. **Photographs of documentation is not accepted.**
A CME Reporting Form must accompany all CME submitted to NLPR.

Part 1 - CME Information: *(Please complete for each CME submission without certificates)*

Title of CME: _____

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

Learning Outcomes: _____
_____

Key Category: _____
(If multiple Key Categories are met please itemize each separately)

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

**In order 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)

Part 2 - CME Group: *(Please check appropriate group for each CME submission)*

☐ Training Courses without Certificate

A Facilitator signature is required from sessions/courses when certificates are not issued.
COURSE OUTLINE OR AGENDA MUST BE PROVIDED TO BE ELIGIBLE FOR CREDIT.

Facilitator Name: _____ Agency: _____

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

Phone: (H) _____ (C) _____ Email: _____

☐ Self-Research / Review

SYNOPSIS REPORTS MUST INCLUDE RESOURCE INFORMATION TO BE ELIGIBLE FOR CREDIT.
Reports must outline learned objectives after reading educational materials; professional practice articles; etc. and how it applies to the Paramedicine environment. CME hours are determined based upon the overall content of the combined synopsis report and length of resources reviewed.

Provider Verification: *(Must be completed by Provider)*

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

Provider Name: _____ Licence #: _____

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

NLPR use only : *(To be completed by NLPR following submission)*

Evaluation of CME: _____ Total Hours: _____

☐ Approved Approval # _____ Received _____

☐ Not Approved Entered _____

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