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|  |  |  |  |  | **APLS** | **PALS** |  |  |
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| 3 | Click here to enter text. | F/P | Date | Click here to enter text. | Date |[ ] [ ]  Date | Click here to enter text. |
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| 51 | Click here to enter text. | F/P | Date | Click here to enter text. | Date |[ ] [ ]  Date | Click here to enter text. |
| 52 | Click here to enter text. | F/P | Date | Click here to enter text. | Date |[ ] [ ]  Date | Click here to enter text. |
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| 54 | Click here to enter text. | F/P | Date | Click here to enter text. | Date |[ ] [ ]  Date | Click here to enter text. |
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| 61 | Click here to enter text. | F/P | Date | Click here to enter text. | Date |[ ] [ ]  Date | Click here to enter text. |
| 62 | Click here to enter text. | F/P | Date | Click here to enter text. | Date |[ ] [ ]  Date | Click here to enter text. |
| 63 | Click here to enter text. | F/P | Date | Click here to enter text. | Date |[ ] [ ]  Date | Click here to enter text. |
| 64 | Click here to enter text. | F/P | Date | Click here to enter text. | Date |[ ] [ ]  Date | Click here to enter text. |
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| 72 | Click here to enter text. | F/P | Date | Click here to enter text. | Date |[ ] [ ]  Date | Click here to enter text. |
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| **Hospital CEO/Administrator** |  | **Hospital CEO/Administrator** |  |  |
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| (Note: The signature of the Hospital CEO/Administrator verifies that all information is current and accurate.) |

* List each physician by name.
* Indicate full time or part time and date of ED hire.
* List all credentials that qualify physician for EDAP or SEDP status. For all physicians who do not meet any of the Board Certifications listed below and who do not meet Alternate Criteria requirements, submit their curriculum vitae, other Board Certifications and copies of their Residency Completion.
* Identify any physicians that meet Alternate Criteria requirements and submit required documentation including confirmation of hours worked (Adm. Code 515.4000 a,1,D)
* Identify completion of APLS or PALS and expiration date. Submit a copy of a current AHA PALS or ACEP-AAP APLS card for those physicians who meet Alternate Criteria.
* Identify the number of pediatric CME hours completed within the past 2 years. Submit a copy of pediatric CME hours for those physicians who meet Alternate Criteria.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Physician Name | F=Full TimeP=Part Time | Date of ED Hire | Board Certification **(Or Board Eligible in 1st cycle)****ABEM/AOBEM/ABP/AOBP/ABFM/AOBFMor** **Alternate Criteria** | **Exp.**or**MOC****Exp.**Date | **CourseCompletion** | Exp.Date | # of HRS of Pediatric Emergency related CME**(16 HRS/past 2 years required)** |
|  |  |  |  |  | **APLS** | **PALS** |  |  |
| 91 | Click here to enter text. | F/P | Date | Click here to enter text. | Date |[ ] [ ]  Date | Click here to enter text. |
| 92 | Click here to enter text. | F/P | Date | Click here to enter text. | Date |[ ] [ ]  Date | Click here to enter text. |
| 93 | Click here to enter text. | F/P | Date | Click here to enter text. | Date |[ ] [ ]  Date | Click here to enter text. |
| 94 | Click here to enter text. | F/P | Date | Click here to enter text. | Date |[ ] [ ]  Date | Click here to enter text. |
| 95 | Click here to enter text. | F/P | Date | Click here to enter text. | Date |[ ] [ ]  Date | Click here to enter text. |
| 96 | Click here to enter text. | F/P | Date | Click here to enter text. | Date |[ ] [ ]  Date | Click here to enter text. |
| 97 | Click here to enter text. | F/P | Date | Click here to enter text. | Date |[ ] [ ]  Date | Click here to enter text. |
| 98 | Click here to enter text. | F/P | Date | Click here to enter text. | Date |[ ] [ ]  Date | Click here to enter text. |
| 99 | Click here to enter text. | F/P | Date | Click here to enter text. | Date |[ ] [ ]  Date | Click here to enter text. |
| 100 | Click here to enter text. | F/P | Date | Click here to enter text. | Date |[ ] [ ]  Date | Click here to enter text. |

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|  |  | Click here to enter text. |  | Click here to enter text. |
| **Signature** |  | **Typed Name** |  | **Date** |
| **Hospital CEO/Administrator** |  | **Hospital CEO/Administrator** |  |  |
|  |  |  |  |  |
| (Note: The signature of the Hospital CEO/Administrator verifies that all information is current and accurate.) |