QUINCY AREA EMS SYSTEM

STUDY GUIDE

EMT-B, FR, FR-D, and EMD

2012 Version

Each agency should have a copy of
QAEMS Policy & Procedure Manual.

A copy is also available on-line at:
blessinghealthsystem.org
Click "**Community Resources**"
Click "**Emergency Medical Services**" in the drop down menu, then
Click "**Download PDF version of QAEMS Policy & Procedure Manual**"

07/08, 03/12, 05/12

EMD complete questions 1 - 15 only.
FR and FR-D complete questions 1 - 35 only.
EMT-B complete the entire exam (1 - 50)

1. Which is NOT CORRECT regarding patient confidentiality?

   A. Prehospital personnel and others functioning within the Quincy Area EMS System will maintain confidentiality regarding patients and patient care.
   B. Information accorded to physicians and/or nurses at the receiving or Resource Hospital should be of a medical nature or pertinent to the care of the patient.
   C. Information will be provided to law enforcement agencies or other governmental agencies as required by Illinois law.
   D. All records will be maintained in public files.

   (O-11)

2. The final designated medical authority in the EMS System is the:

   I. The EMS Medical Director is the designated final medical authority.
   II. The first arriving EMS team on the scene is responsible under the direct authority of the EMS Medical Director and will assume responsibility for carrying out appropriate patient care at the scene.
   III. Responsibility and authority for patient care management will be transferred to the team providing the highest level of care at the scene upon their arrival.

   (O-1)

3. The disaster tag system used in the QAEMS System in the event of a major EMS Incident is called the:

   QAEMS SYSTEM USES **SMART TAG** beginning Fall 2008 (O-12-F)

4. The START program is used to triage patients. It consist of three basic components which are

   START TRIAGE - ADULT
   STEP 1: Respiration's (breathing)
   STEP 2: Perfusion check (radial pulse) or use capillary refill test
   STEP 3: Mental Status

   (O-12.b)

5. Criteria to request a scene response by a helicopter air ambulance would include:

   AIR AMBULANCE UTILIZATION PROTOCOL Criteria:
   A. Category I trauma or seriously ill patient in remote or off-road locations not easily accessible to ground ambulances, or whose location may cause delay in transport time.
   B. MVC or incident with prolonged extrication time anticipated (> 20 minutes).
   C. Special environmental conditions such as extreme heat or cold which affect potential patient outcome or prohibit ground access to the hospital (road or bridge damage).
   D. No available trauma center within 20 minutes by ground transport time.
   E. Reduction in transport time to a trauma center compared to ground transport for the seriously injured patient
   F. Ground transport resources are exhausted or exceeded (multi-casualty or multiple calls).

   (O-28.1)

6. Examples of possible System-wide crises that might necessitate activation of the System Wide Crisis plan includes all of the following EXCEPT:

Examples of possible System-wide crises:

1. Heat emergency
2. Communicable disease
3. Influenza epidemic
4. Terrorist act involving a nuclear, biological or chemical agent

(O-32.1)

7. The ten-codes used for medical communications in the QAEMS system include all EXCEPT:

Five 10 signals that shall be used for medical communications to the hospital:

10-33 Run Emergent (HOT)
10-40 Run Non-Emergent (COLD)
10-56 Intoxicated
10-79 Dead body
10-96 Psychiatric patient

(C-4)

8. What is the purpose of a local system review board?

Purpose:

The Resource Hospital shall designate a Local System Review Board for the purpose of reviewing a decision of the EMS Medical Director to suspend an individual, individual provider or participant from participation in the Quincy Area EMS System.

(PS-1.1)

9. Any participant in the EMS System may be suspended by the EMS Medical Director for any of the following reasons EXCEPT:

Any such suspension may be based on one or more of the following:

A. Failure to meet the educational and training requirements of the State or by the EMS Medical Director.
B. Violation of the EMS act or any rule promulgated under it.
C. Failure to maintain proficiency in the provision of basic or advanced life support services.
D. Failure to comply with System Policies and Procedures.
E. Intoxication or personal misuse of any drugs or the use of intoxicating liquors, narcotics, controlled substances, or other drugs or stimulants in such manner as to adversely affect the delivery, performance, or activities in the care of patients.
F. Falsification of any reports or orders, or making misrepresentations involving pt. care.
G. Abandoning or neglecting a patient requiring emergency care.
H. Unauthorized use or removal of narcotics, drugs, supplies or equipment from any ambulance, health care facility, institution, or other work place location.
I. Performing or attempting emergency care, techniques or procedures without proper permission, certification, training, or suspension.
J. Discriminating in rendering care due to race, sex, creed, religion, national origin or ability to pay.
K. Medical misconduct or incompetence.
L. Physical impairment to the extent that emergency care and life support functions for which the provider is certified, cannot be physically performed.
M. Mental impairment to the extent that the appropriate judgment, skill and safety required for performing the emergency care and life support functions for which the provider is certified cannot be exercised.
N. The EMS Medical Director believes that the continuation in practice by the provider would constitute an imminent danger to the public.
O. Committing a felony act while on or off duty. (PS-2)

10. Event Reports should be completed and filed with the EMS Office in all of the following instances EXCEPT:

Event Reports

a. Improving the management and treatment of patients in the system
b. Inservice education of personnel
c. Administrative supervision
d. Medico-legal coverage

(PS-3)

11. Which is NOT an objective of quality assurance reviews in the Quincy Area EMS System?

Objectives of quality assurance reviews

A. Review effectiveness of policies and procedures
B. Detect trends and repeated errors
C. Identify and acknowledge exceptional performance
D. Identify and correct substandard performance (QA-2.1)

12. Duties of the First Responder does not include:

First Response Services (Duties):

A. CPR
B. Monitoring vital signs
C. Control of bleeding
D. Use of oropharyngeal airways/nasopharyngeal airways
E. Oxygenation/assist ventilations with pocket mask or bag valve mask
F. Splinting/bandaging

(P-30)

13. Which is NOT a duty of the Emergency Medical Dispatcher?

EMD Duties:

A. Accepts calls from the public for emergency medical services.
B. Dispatches designated emergency medical services personnel and vehicles.
C. Provides pre-arrival medical instructions to the caller in accordance with protocols approved by the EMS Medical Director.

(P-32)

14. Which statement regarding patient refusal is correct?

REFUSALS

Who May Refuse Care: A patient may refuse medical care and/or transportation if he/she does not appear to be a threat to himself or others and meets the following criteria:

A. A competent, conscious adult over the age of 18
B. A minor (under age 18) who meets one or more of the following criteria:
    1) Has been granted legal emancipation and provides documentation
    2) Is pregnant
    3) Is a parent
C. A Durable Power of Attorney for Health Care may request to limit or refuse medical care.
D. The legal guardian or parent of a minor

(O-6.1)

15. In order to re-license as a FR, EMT-B or EMD, continuing education hours and copy of current CPR card should be submitted to:

Relicense
Members of the QAEMS System submit required hours and copy of CPR card directly to the EMS Office. If requirements are met, the Medical Director authorizes IDPH to issue a new license.

(P-30, 31, 32)

EMD – stop here.

16. Regarding a physician at the scene who is a bystander, all of the following are true EXCEPT:

Physician is a Bystander:
A. Require identification
B. Determine if physician is willing to assume responsibility for patient care and accompany patient to the hospital.
C. Confirm all orders with Medical Control.

(O-3)

17. All of the following may refuse treatment and/or transport EXCEPT:

REFUSALS
Who May Refuse Care: A patient may refuse medical care and/or transportation if he/she does not appear to be a threat to himself or others and meets the following criteria:
A. A competent, conscious adult over the age of 18
B. A minor (under age 18) who meets one or more of the following criteria:
   1. Has been granted legal emancipation and provides documentation
   2. is pregnant
   3. Is a parent
C. A Durable Power of Attorney for Health Care may request to limit or refuse medical care.
D. The legal guardian or parent of a minor

(O-6.1)

18. The objective of physical restraint for a patient demonstrating a behavioral emergency is to:

NEED FOR RESTRAINT
Physical restraint may be necessary when EMS personnel have a reasonable belief that the patient may harm himself or others.

(O-8)

19. If a patient is found to be pulseless and apneic and does not meet the criteria for initiation of resuscitative efforts, emergency personnel should next:

[Before] CONTACTING CORONER
A. Advise the medical control physician
   1) Communicate pertinent medical history (use cell phone if possible)
   2) Transmit a sample EKG if requested (ACLS)
B. Notify the coroner on all prehospital deaths (after contact with Medical Control)
   1) Contact dispatch and advise of need for coroner

(O-9)

20. All pulseless and non breathing patients are to receive full resuscitative efforts except in certain circumstances. A reason to NOT to initiate resuscitative efforts include all of the following EXCEPT:

All pulseless and non breathing patients are to receive full resuscitative efforts except when any of the following physical findings can be documented:

A. rigor mortis
B. tissue decomposition
C. extreme dependent lividity
D. injuries incompatible with life
    1. decapitation
    2. incineration
    3. etc

(O-9A)

21. A valid Do Not Resuscitate order for pre-hospital personnel must contain all of the following information EXCEPT:

DNR Orders

A. name of patient
B. name and signature of attending physician
C. effective date
D. the words written out "Do Not Resuscitate"
E. evidence of consent either:
    1. signature of patient; or
    2. signature of legal guardian; or
    3. signature of durable power of attorney for health care agent; or
    4. signature of surrogate decision maker

(O-9B.1)

22. Which of the following statements regarding the care of an amputated part is NOT true?

PREHOSPITAL PROTOCOL FOR AMPUTATED PARTS

Prehospital protocol for handling amputated parts intended for reanastomosis.

-Any gross contaminants on the part should be removed by rinsing the part in sterile saline solution.
-No attempt should be made to debride or otherwise clean up the amputated part.
-The part should be rinsed, wrapped in a moist but not wet sterile dressing, placed in a plastic bag and tightly sealed to prevent direct contact with liquid substances. The sealed bag should then be placed in iced saline or sterile water.
-Cover stump with sterile dressing.
-Patient transport should not be delayed by the search for the amputated part. Search can be continued by other personnel (i.e. 2nd ambulance, fire, law enforcement) while patient is transported.

(MP-3)

23. Which of the following statements is true regarding the prehospital treatment of serious burns for first responders?

Treatment of Burns

A. Airway Management - be alert to the possibility of associated pulmonary injuries if the burn occurred in an enclosed space or during an explosion. Note any toxic fumes.
   1. Ensure patent airway
   2. Suction if necessary
   3. Utilize oral or nasal airway as needed
   4. Perform endotracheal intubation if necessary (ALS)

B. Oxygenation/Ventilation
   1. Administer oxygen
   2. Assist ventilations if necessary
   3. Monitor O2 saturation if pulse oximetry is available

C. Other
   1. Ensure smoldering clothing has been extinguished
   2. Cut off clothing
   3. Remove metal jewelry/leather articles
   4. Do not apply topical ointments at the scene
   5. Do not remove tar or asphalt unless it affects the airway
   6. The usual rules of splinting apply
      a) Air splints may be applied over the burn if necessary
      b) Traction splints may be applied to lower extremities if necessary
      c) Attempt to protect burned areas from pressure
      d) Transport on clean sheets
   7. Monitor vital signs and respiratory status closely
   8. Do not allow the patient to become hypothermic

(MP-5)

24. Prehospital treatment of isolated frostbite may include all of the following EXCEPT:

Isolated Frostbite

Treatment:

Move the patient to a warm environment.
Remove wet, restrictive clothing.
Cover affected areas with dry, sterile dressings.
Prevent thawing/re-freezing of the affected areas.
Rewarming of frostbitten tissue is best performed in the controlled setting of the emergency department.

(MP-20)

25. Prior to expiration of a FR-D/EMT-B license, a provider may request to be placed on inactive status if all relicensure requirements have been met at that time. During inactive status:

Request for Inactive Status

During inactive status, the EMT shall not function as an EMT, at any level.

(P-17)

26. You are called to a local residence for an injured child. All of the following might be indications of child abuse EXCEPT.

Possible Indicators of Abuse and/or Neglect:

-Obvious or suspected fractures in a child under age two.
-Injuries in various stages of healing, especially burns or bruises.
-Injuries scattered over many body parts.
-Bruises or burns in a pattern which suggests intentional infliction.
-Injuries which do not match the history.
-Vague, inconsistent or changing history.
-Delay in seeking treatment.
-Inappropriate clothing, signs of poor nutrition or poor care.
-Abandonment of an elderly person or child unable to care for themselves.

(MP-23.1)

27. A general approach to the stable, conscious pediatric patient would include:

General Approach to the Stable/Conscious Pediatric Patient

A. Assessments and interventions must be tailored to each child in terms of age, size and development.
   1. Smile if appropriate to the situation
   2. Keep voice at even quiet tone, don't yell.
   3. Speak slowly: use simple, age appropriate terms.
   4. Use toys or penlight as distractors: make a game of assessment
   5. Keep small children with their caregiver(s); encourage assessment while caregiver is holding child.
   6. Kneel down to the level of the child if possible.
   7. Be cautious in use of touch. In the stable child, make as many observations as possible before touching (and potentially upsetting) the child.
   8. Adolescents may need to be interviewed without their caregivers present if accurate information is to be obtained regarding drug use, alcohol use, LMP, sexual activity, child abuse.

(PED 1.1)

28. The Cincinnati stroke scale includes all of the following parameters EXCEPT:

CINCINNATI STROKE SCALE – 3 COMPONENTS.

1. Facial droop (Ask the patient to smile)
2. Speech (Ask the patient to repeat a simple sentence.)
3. Arm drift (Ask patient to close eyes and hold arms straight out in front of them.)

(MP-26)

29. Your assessment reveals suspicious bruising on a 12 month old infant. As a mandated reporter, you would report your findings/suspicions to all of the following EXCEPT:

Report suspicions to ED physician, ED charge nurse and DCFS (1-800-25-ABUSE)

(PED-20)

30. Which of the following is NOT an indication for spinal immobilization?

INDICATIONS for spinal immobilization

A. All trauma patients with a neurological deficit.
B. All trauma victims complaining of head, neck, or back pain.
C. All unconscious trauma victims.
D. All trauma victims who may have spinal injury, who also exhibit altered mental states, (e.g., drugs, alcohol).
E. All trauma victims with facial or head injuries.
F. All trauma patients with "mechanism of injury" that may have resulted in spinal injury.

(AP-2.1)

31. Which equipment is not a part of the First Responder's "Jump Kit"?

Equipment (As a minimum this equipment must be immediately available to the First Responder)

A. Triangular bandage
B. Roller type bandage
C. Universal dressing
D. Gauze pads
E. Occlusive dressings
F. Bandage scissors
G. Adhesive tape
H. Stick (for impaled object/tourniquet)
I. Blanket
J. Upper extremity splint
K. Lower extremity splint (set)
L. O2 equipment and masks (adult and pediatric)
M. Bag mask resuscitator
N. Oropharyngeal airways (adult, child, infant)
O. Optional equipment: AED (for First Responder AED only)

(O-31)

32. For license renewal, a First Responder-D must have a minimum of _____hours of continuing education in a four year period while EMT-Bs must have _____ hours.

Registration: To maintain status as a registered First Responder authorized to participate in the Quincy Area EMS System, the following established requirements must be met:

A. Participate in 24 hours of continuing education every four years (6 hours per year). Submit documentation of these hours to the EMS Office at least 75 days prior to the registration expiration. (EMT-Bs are required to submit 120 hrs.)

(P-31)

33. Treatment for the victim of a heat related emergency may include:

Heat Exhaustion/Heat Stroke

A. Treatment
    1. Move the patient to a cool environment
    2. Remove excessive clothing.
    3. If hypotensive or unconscious:
        1. maintain an open airway
        2. oxygen per nasal cannula or mask as needed.
        3. initiate an IV of normal saline and administer an initial fluid bolus of 200 cc. (ALS).
        4. monitor cardiac rhythm (ALS).
        5. perform and transmit 12 lead EKG if possible (ALS).
        6. initiate cooling of the heat stroke victim with cold packs or cool soaks to the neck, axilla, and groin.

(MP-19)

34. Which could be considered a form of child neglect?

The following are some common forms of neglect

a) Environment is dangerous to the child (e.g., weapons within reach, playing near open windows without screen/guards, perilously unsanitary conditions, etc.).
b) Caretaker has not provided, or refuses to permit medical treatment of child's acute or chronic life-threatening illness, or of chronic illness, or fails to seek necessary and timely medical care for child
c) Child under the age of 10 has been left unattended or unsupervised. (Although in some situations children under 10 years of age may be left alone without endangerment, EMS personnel cannot make such determinations). All instances should be reported for DCFS investigation.
d) Abandonment
e) Caretaker appears to be incapacitated (e.g., extreme drug/alcohol intoxication, disabling psychiatric symptoms, prostrating illness) and cannot meet child's care requirements.
f) Child appears inadequately fed (e.g., seriously underweight, emaciated, or dehydrated) inadequately clothes, or inadequately sheltered.
g) Child is found to be intoxicated or under the influence of an illicit substance(s).

(PED-20.2)

35. The DUTIES of a First Responder include:

First Response Services (Duties):

A. CPR
B. Monitoring vital signs
C. Control of bleeding
D. Use of oropharyngeal airways/nasopharyngeal airways
E. Oxygenation/assist ventilations with pocket mask or bag valve mask
F. Splinting/bandaging

(P-30)

FR and FR-D stop here!

36. Appropriate care of uninjured students involved in a Category II bus accident include:

Category II or III bus accident/incident.

1. Contact Medical Control, advise of the existence of Category II or III bus accident/incident and determine if a scene discharge of uninjured children/students by the ER Physician in charge of the call is appropriate.
2. Injured children/students by exam and/or complaint are treated and transported as deemed necessary and appropriate by EMS personnel or at the request of the student.
3. Implement provider procedures for contacting school officials or parent/legal guardians to receive custody of the uninjured students consistent with region III policy. Procedure may include option of ambulance service provider escorting bus, if operable, back to school of origin or other appropriate destination.
4. Medical Control, after consulting with scene personnel, will discharge the uninjured students to the custody of the ambulance service provider who then will transfer the custody of the students, consistent with appropriate department and regional policies and procedures, to parent/legal guardians or school officials.
5. Authorized school representatives will sign the log sheet indicating acceptance of responsibility for the students after medical clearance by the EMS personnel finding NO evidence of injury. The school representative will then follow their own policies to include informing the parents/legal guardians as regards to the accident/incident.
6. Any student having reached the age of 18 or older and any adult non-student present on the bus will initial the log sheet adjacent to their name and address when in agreement that they have suffered no injury and are not requesting medical care and/or transport to the hospital.
7. Complete one Prehospital Care Report Form in addition to the School Bus Incident From.

(O-37.1)

37. Which of the following is a duty of the Emergency Communications RN (ECRN)?

ECRN DUTIES AND RESPONSIBILITIES

G. Give voice orders to system participants via radio in accordance with System approved protocols.
H. Document calls for which direction was given completely and accurately recording information as required on the emergency department Radio Log.
I. Sign the patient report form of the transporting unit indicating transfer of patient care to the receiving hospital.
J. Monitor, supervise, and assist hospital personnel fulfilling educational requirements in the clinical setting.
K. Perform other duties as may be assigned by the EMS Medical Director.
L. Monitor conformance to system policy and procedure

(P-13)

38. Duties of the EMT-B include all of the following except:

EMT-B DUTIES

A. Abdominal thrusts
B. Administration of oral and sublingual glucose
C. Assist patients with taking certain medications
D. Bag-valve mask ventilation
E. Cardiopulmonary resuscitation
F. Demand valve ventilation
G. Emergency vehicle operation
H. Hemorrhage control
I. Insertion of nasopharyngeal airways
J. Insertion of oropharyngeal airways
K. Mouth to mask ventilation
L. Obtain a patient history
M. Open an airway using the head tilt-chin lift, and jaw thrust methods
N. Patient extrication
O. Patient packaging
P. Pneumatic anti-shock garment application
Q. Positive pressure ventilation
R. Primary survey
S. Record and communicate information gathered during the patient examination
T. Secondary survey
U. Supplemental oxygen delivery

(P-3)

39. Which statement is NOT true regarding the EMT-B request for a voluntary reduction of certification to the First Responder level?

EMT Reduction to First Responder Level:

A. At any time prior to the expiration of their current license, an EMT may revert to First Responder status for the remainder of the license period.
B. The request shall be made in writing to the EMS Medical Director who will forward the request to the Department.
C. Once registered as a First Responder, the individual must meet requirements for First Responder registration.
D. Once registered as First Responder, the provider can not be reinstated to EMT status unless the entire training program is taken.

(P-29.2)

40. An EMS physician must be called to the operational control point at Medical Control EXCEPT when:

PHYSICIAN TO THE OPERATIONAL CONTROL POINT (RADIO)

A. A decision regarding where a patient is to be transported needs to be made by the resource hospital. (see policy O-4)
B. Intervention by the resource hospital is indicated. (see policy O-5)
C. A major EMS incident is declared.
D. When a Quincy ALS unit is requesting permission to respond to a second and simultaneous dual response.
E. When an ALS crew is requesting an infield service level downgrade.

(O-18)

41. Patients with serious trauma often need interventions that are not available in the prehospital setting. All of the following are considered "load and go" conditions EXCEPT:

The following are critical situations that require **"load and go"**
-Cardiac/respiratory arrest
-Obstructed airway
-Decreased level of consciousness
-Respiratory difficulty
-Signs of shock
-Injuries that will rapidly lead to shock or respiratory difficulty:
*flail chest
*open pneumothorax
*tender abdomen
*unstable pelvis
*bilateral femur fractures
*poorly controlled major bleeding

(O-23)

42. Prior to dispatching ALS assistance to an incoming ambulance with a serious injury, Medical Control or the receiving facility should:

Prior to dispatching ALS assistance, the receiving hospital should weigh the benefits of the ALS assistance to the patient against the ETA to the hospital and subsequent delay in transport that would occur.

(C-2)

43. Any participant in the EMS System may be suspended by the EMS Medical Director for any of the following reasons EXCEPT:

Any such suspension may be based on one or more of the following:

A. Failure to meet the educational and training requirements of the State or by the EMS Medical Director.
B. Violation of the EMS act or any rule promulgated under it.
C. Failure to maintain proficiency in the provision of basic or advanced life support services.
D. Failure to comply with System Policies and Procedures.
E. Intoxication or personal misuse of any drugs or the use of intoxicating liquors, narcotics, controlled substances, or other drugs or stimulants in such manner as to adversely affect the delivery, performance, or activities in the care of patients.
F. Falsification of any reports or orders, or making misrepresentations involving pt. care.
G. Abandoning or neglecting a patient requiring emergency care.
H. Unauthorized use or removal of narcotics, drugs, supplies or equipment from any ambulance, health care facility, institution, or other work place location.
I. Performing or attempting emergency care, techniques or procedures without proper permission, certification, training, or suspension.
J. Discriminating in rendering care due to race, sex, creed, religion, national origin or ability to pay.
K. Medical misconduct or incompetence.
L. Physical impairment to the extent that emergency care and life support functions for which the provider is certified, cannot be physically performed.
M. Mental impairment to the extent that the appropriate judgment, skill and safety required for performing the emergency care and life support functions for which the provider is certified cannot be exercised.
N. The EMS Medical Director believes that the continuation in practice by the provider would constitute an imminent danger to the public.
O. Committing a felony act while on or off duty.

(PS-2)

44. Appropriate prehospital care for the OB/GYN patient exhibiting a prolapsed umbilical cord may include all of the following EXCEPT:

If the umbilical cord is noted to be protruding from the vagina:

1. Administer oxygen at 15 LPM per non-rebreather mask to the mother
2. Place the mother in knee-chest or Trendelenberg position
3. Insert two fingers of a gloved hand into the vagina to raise the presenting part off the cord. This position will need to be maintained until instructed otherwise at the hospital. At the same time check the cord for pulsations.
4. Cover the exposed cord with a moist sterile dressing. Do not compress, palpate or handle the cord more than necessary

(MP-10.2)

45. For the normal spontaneous emergency delivery in the field, an APGAR score (appearance, pulse, grimace, activity, respirations) should be done:

APGAR SCORING

Note APGAR score at 1 minute and 5 minutes post delivery.

(MP-10.1)

46. The ten-codes used for medical communications in the QAEMS system include all EXCEPT:

Five 10 signals that shall be used for medical communications to the hospital:

10-33 Run Emergent (HOT)
10-40 Run Non-Emergent (COLD)
10-56 Intoxicated
10-79 Dead body
10-96 Psychiatric patient

(C-4)

47. The EMT-B may assist a patient with which of the following medications after contact with Medical Control?

The EMT-B may assist the patient with certain medications. They are: Nitroglycerin (SL), Auto-injector/Epi-pen (Sub-q), a prescribed [respiratory] inhaler. The EMT-B may assist the patient only after all of the following conditions have been met:

- There are specific chief complaints
- The medication is prescribed for the patient
- The medication is not expired
- Medical control has been contacted with a patient report
- Medical control authorizes the dosage route, times, and administration

(MP-24.2)

48. Signs/symptoms of a partial airway obstruction in a child may include:

Partial Airway Obstruction

-suspected foreign body obstruction or epiglottitis
-stridor
-choking
-drooling
-hoarseness
-retractions
-tripod position (PED-7.1)

49. The only absolute contraindication for use of a pneumatic antishock garment (MAST) is:

CONTRAINDICATIONS

a. Pulmonary Edema
b. Evisceration (may use leg compartments)
c. Pregnancy (may use leg compartments)

(AP-3.1)

50. Recertification at the end of a four-year license period for an EMT-B includes:

EMT-B RECERTIFICATION REQUIREMENTS

To maintain status as a fully licensed EMT-B authorized to participate in the Quincy Area EMS System, and to remain eligible for re-licensure every four years, the following established requirements must be met:

A. Participation in 120 hours of approved continuing medical education every four years. No more than 25% of those hours may be in the same subject.
B. Maintain current American Heart Association CPR provider certification, or equivalent (renewal every year).
C. 8 hours/4-year period must be pediatric related programs.

(P-23)

General Information:

A. No more than twenty-five percent (25%) of the total hours required for relicensure may be obtained in the same subject. Repetition of a specific class session within a 12 month period will not be accepted for credit.
B. At least fifty percent (50%) of the total hours required for relicensure should be earned through System taught courses.
C. 8 hours/4 years must be in pediatric topics (EMTB) (CET 2.1)