Applicant Guide to

EMA Licensing Examinations

EMERGENCY MEDICAL ASSISTANTS
LICENSING BOARD

June 2007

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INTRODUCTION

This guide provides direction for candidates with certification training within British Columbia, who are pursuing an EMA license to practice in British Columbia. It provides practical insight into the examination and license application processes. Applicants with certification training outside of British Columbia should go to the EMA Licensing public web site for information related to application for equivalency assessment and licensure in British Columbia.

Upon completion of certification training, a successful graduate is issued a certificate from the training agency. In order to be licensed, the graduate must complete EMA Licensing examination requirements comprised of a written (where applicable) and practical evaluation.

The information in this booklet is provided to help guide applicants through the EMA Licensing process. It outlines the application process (including forms and picture requirements) and the licensing examinations. It also provides important web site addresses, contacts and phone numbers.

Important Notes

- Applicants require internet access. Applicants, who are unable to obtain internet access, should notify EMA Licensing.
- It is the responsibility of the applicant to arrange for the date and location of the EMA Licensing evaluation. The training agency is not responsible for facilitating this process.
- Licensing evaluations must be successfully completed within one year of course completion.
- Applicants should contact this office if they have any questions or require assistance.

EMA Licensing Contact Information

Mailing Address:
EMA Licensing
PO Box 9625 Stn Prov Govt
Victoria BC V8W 9P1

Fax: (250) 952-1222
Phone: (250) 952-1211
Email: emalb@victoria1.gov.bc.ca
Intranet: admin.moh.hnet.bc.ca/emaintra

EVALUATION PROCESS - SUMMARY

A user ID and password are required to access the EMA Licensing intranet website. BCAS employees should use their station ID and password. All other individuals can request a user ID and password by following the instructions in the How to Access the EMA Licensing Intranet Website section of this booklet.

The evaluation scheduling forms and information are located on the EMA Licensing website under Resources: "Exams – Schedule an Evaluation Date".

Required Documents

- Application for License Form
- Proof of course completion – copy of certificate or official transcript
- Recent photo –see Photograph for License Application section for requirements
- Practical Evaluation Booking Form
- Written Evaluation Booking Form (if a written exam is part of your evaluation requirements)
- Payment of the license evaluation fee is required prior to eligibility for any exam. A schedule of fees is outlined in Appendix J. This fee is payable by cheque or money order only – made out the Minister of Finance and mailed to this office. Please ensure your name is recorded clearly on the cheque or on the accompanying letter.

Proof of course completion, the Application for License form and fee payment is prerequisites to booking any evaluation. You will not be registered for an exam until receipt of all required documents.

Do not re-submit the application, proof of completion and photograph if booking a remedial exam since they are on file from the original evaluation booking.

Evaluation requirements for the various license levels are outlined on the Evaluation Booking section of the EMA Licensing intranet website. Written and practical components must be booked separately using the web-based forms on the website.

Practical Evaluations

Access the Evaluation Booking web pages and submit the Practical Evaluation Booking form. Choose any location and any exam session listed on the Practical Examination Schedule. Ensure you request exam sessions for which the associated registration deadline has not passed.

The Practical Examination schedule lists all exam sessions scheduled throughout the province[1]. Specific requests may be noted in the comment field of the booking form.

[1] Applicants should review this list and then using the Practical Evaluation Booking form submit the exam sessions which best suit them.

You may also use the comment section to request to be put on the waiting list for an exam session for which the registration deadline has passed. We will do our best to accommodate the first choice for exam date, but it is not always possible.

Applicants will be enrolled in one of the five days of the session in which they are registered. Confirmation of exam date will be sent via email approximately three weeks prior to the exam session. Applicants must contact this office with at least 48 hours notice if they must cancel their exam date for any reason.

Details of the practical exam structure are outlined in the Practical Examination Information section. See Appendix B for a sample practical scenario.

Written Evaluations

Written exams must be booked separately from the practical exam. Written exams can be proctored in communities throughout the Province. Approved proctors in BC are Government Agent offices, BCAS Human Resources offices, the EMA licensing Branch office in Victoria well as others in the smaller communities of BC. [2]

A list of approved proctors in BC is listed in Appendix K.

It is up to the applicant to make arrangements with the proctor. Arrangements must be made prior to submitting the booking form. Contact one of the approved proctors, make arrangements for a date and time for your written exam to take place; then advise this office by submitting the Written Evaluation Booking Form. The Applicant must provide enough notice to allow time for the exam package to arrive to the proctor in the mail. The written examination can take place before or after the practical exam date.

Confirmation of exam booking will be sent via email to the Applicant with a copy to the proctor, on the day the exam package is mailed.

Details of the written examination structure are located in the Written Examination Information section. See Appendix A for sample written examination questions.

[2] Government Agent locations are listed under Locations on the Service BC Government Agents website at the following URL: http://www.governmentagents.gov.bc.ca/

HOW TO ACCESS THE EMA LICENSING INTRANET WEBSITE

A user ID and password are required to access the EMA Licensing intranet website.

BCAS employees should use the group user ids and passwords which were assigned to all the BCAS stations.

All other individuals can request a user ID and password by going to the following URL and selecting "New Users Register Here": http://admin.moh.hnet.bc.ca/

The registration request page will come up. Leave "no" selected and click on continue. Fill out the information on the Registration Request form.

The URL for the EMA Licensing intranet site is: http://admin.moh.hnet.bc.ca/emaintra. The site may also be found by going to the main health intranet site (http://admin.moh.hnet.bc.ca/) and selecting "Partnership Matters". The EMA Licensing site is listed alphabetically.

Both the ID and password are required to access the site. If a password is forgotten

COMPLETION OF THE APPLICATION FOR LICENSE FORM

It is imperative that this form be legible. It can be filled out online but must be printed, signed and dated. Unsigned forms will not be accepted. If this form must be filled out by hand, please ensure all information is recorded legibly.

Part A

- Name - middle name must be included
- Address – include province
- Telephone – additional phone numbers on the bottom of the form in the comments section.
- Email address - make sure any underscores are visible above the line.
- Birth date – please use yyyy/mm/dd format
- Height, weight, eye and hair colour – these fields are required and a license will not be issued without this information.

Part B

- If employed by the BCAS, record ‘BCAS’ in the Employer field and the Station number in the Dept. Number field. No other contact info is required.
- If employed by the Department of National Defense, please record ‘DND’ in the Employer field. No other contact information is required.
- If the EMA license is used while performing duties elsewhere, employer information must be recorded. The contact person should be the General Manager, Head Administrator or equivalent.
- If the EMA license is not used for employment, leave the entire section blank.
- It is imperative that EMA Licensing be informed in writing of changes in employment. EMA Regulations stipulate that license status, category, or endorsement change notices be copied to the employer.

Part C

- Fill in license category and endorsements applied for. For details on the endorsements each license level is entitled to, please refer to the EMA Regulations that are available on the EMA Licensing intranet website.
- License number – Use the license number issued upon initial registration. If it is the initial registration, leave the field blank.
- Signature is required. A license will not be issued if the application form is not signed.

If required, contact EMA Licensing for further information about this form.

PHOTOGRAPH FOR LICENSE APPLICATION

Image Requirements:

- Eyes must be open and clearly visible. Glasses, including tinted ones with prescription, may be worn as long as the eyes are clearly visible. Sunglasses are unacceptable.
- Photo must show a full front view of the face with both edges of the face showing clearly. The face and shoulders must be centered in the photo and squared to the camera.
- Photo must reflect natural skin tones.
- The image must be clear, sharp and in focus.
- Photo must be taken with uniform lighting and not show shadows or flash reflection on the face and head. Photos with shadows on the face or background are unacceptable.
- Photos should be taken against a plain, uniform, white or light-colored background.
- Hats or head coverings are not permitted except when worn for religious reasons and only if the full facial features are clearly visible.
- Color photos are required.
- Photos must have been taken within the last 12 months.
- Digital photos are preferred.

WRITTEN EXAMINATION INFORMATION

Written exams are subject to the licensing fees as outlined in Appendix J. A written exam, if applicable to the license category applied for, is scheduled separately from the practical examination. Locations to have a written examination proctored are located on the EMA Licensing intranet site under "Resources – Schedule an Examination Date". A list of approved proctor locations in BC is located in Appendix K.

Examination Structure
An applicant has three opportunities to pass the written examination. All three attempts must be made within 12 months of course completion.

After three unsuccessful attempts, or after 12 months, proof of completion of another course must be submitted in order to reapply for an evaluation.

Examination Results
The completed exam is mailed to EMA Licensing for marking. Examination scores are communicated to the applicant by letter as soon as they become available.

Examination Day
Applicants must provide photo ID to the facility proctoring the written examination.

No Communication Devices Permitted - Candidates are not permitted to have communication devices such as PDAs, pagers, cellular phones, or text messaging devices etc., in the testing facility. Nothing can be taken into the examination room other than pens, pencils, erasers and a basic unit calculator with no other capabilities than to provide mathematical calculations. Each examination package will contain scrap paper for use in completing calculations.

Cheating - Candidates deemed by EMA Licensing to be cheating will be disqualified from sitting an examination or will forfeit their results. No other opportunities will be provided to the candidate and the applicant's file will be closed.

Confidentiality - All examination material is the copyright of EMA Licensing. All examination content is to be kept confidential.

Common Errors - Here are some common errors and omissions:

- Not reading the questions carefully
- Reading more into a question than what is provided
- Focusing on advanced procedures and forgetting basic first aid concepts
- Not considering all materials provided by your training agency and EMA Licensing

See Appendix A - Written Examination Sample Questions

PRACTICAL EXAMINATION INFORMATION

Practical evaluations are subject to the licensing fees as outlined in Appendix J. The practical examination takes place over the course of one day and is completed separately from the written examination. Locations for practical examinations are located on the EMA Licensing intranet site under “Resources – Schedule an Examination Date”.

Evaluation Attempts
A maximum of three attempts are permitted within 12 months of course completion.

After three unsuccessful attempts, or after 12 months, proof of completion of another course must be submitted in order to reapply for further evaluation.

Full Call Simulations
Full call simulations may include the use of any of the equipment listed in Appendix I - Practical Examination Equipment List. Partnering with another applicant, who will function as an assistant, and an actor who will be the patient, the examinee must demonstrate all components of the patient assessment model (e.g. scene assessment, personal protection, primary survey, etc) through to transportation and final turnover at a hospital with a full hospital report (given to the evaluator as if s/he were the receiving

nurse/physician). The patient assessment and care provided is expected to follow established guidelines.
An evaluator sets up in a room with a live actor as the patient. The examinee and his partner wait in another location. When the patient is ready, the evaluator will give the dispatch/accident information to the examinee. The evaluation commences when the examinee approaches the patient's side. The examinee completes the call, interacting as much as possible with the patient.

The evaluator will interact with the examinee to provide information or clarification that the patient cannot provide. The examinee completes the call through to transportation and hospital arrival, concluding with a report to the evaluator as the receiving nurse/physician.

The practical simulations end with a short oral component posing questions of a general nature related to the scope of practice, but not necessarily pertaining to the call just completed. For example, if the treated patient experienced shortness of breath, the examinee may be asked general questions on the benefits of oxygen, or be asked to give some examples of the causes of shortness of breath.

Evaluation components in the scenario relate to every aspect of the simulation: Approach/scene assessment, safety concerns, communication, history taking, assessment technique, treatment, transport decisions (including decision to transport and the mode of transport; urgent or routine), recording, reporting and academic understanding. A copy of the patient report is submitted for each call. The report can be completed during the call or following its completion. A copy of the report is found at Appendix H – Patient Care Report.

Skill Tests
Skill tests examine specific skills that applicants are expected to know (e.g. demonstrate how to put on a traction splint or show how to do CPR on an adult, a child and a baby). Skill tests usually take no more than 15 - 20 minutes each and do not usually involve oral questions.

Equipment Used for Evaluations
It is recognized that each training agency or employer may use varying pieces of equipment in their facilities. Consequently, EMA licensing evaluations are based on the objectives of the skills being met rather than the specifics of a particular equipment make or model. For example, an examinee may be instructed in the use of a "Hare" brand traction splint, and the licensing evaluation equipment may be a "Sager" brand traction splint. However, the principles of traction and immobilization remain the same.

Before the examination begins, examinees have the opportunity to familiarize themselves with the equipment used to conduct their evaluation. The program coordinator and/or the evaluators for that day will be in attendance to allow time to clarify any equipment issues that may arise.

It is recommended that examinees supply their own stethoscope and eye goggles for the evaluations in order to minimize the risk of infections and disease contraction.

See Appendix B – Practical Scenario Sample and Appendix I – Practical Examination Equipment List

LICENSE MAINTENANCE

Upon successful completion of the license examination, the applicant is registered by the EMA Licensing Board and issued a five-year license. Notification will go out by mail when the license is due for renewal.

Note: It is imperative that licensees maintain current contact information on file at EMA Licensing (e.g. correct mailing address, phone number(s), name change, employer, etc.). Changes to this information may be sent by mail, fax or email.

Registrants must satisfy annual license maintenance requirements, beginning in the calendar year following license issuance. It is the responsibility of each EMA to be aware of license maintenance requirements for their license level. These requirements include annual submission of 20 patient contacts and 20 continuing education credits. Information on continuing education courses, credits and patient contacts can be obtained on the EMA Licensing Branch intranet web site under “EMA Licensing Board – License Maintenance”.

Letters are sent quarterly to each registrant regarding their patient contact and continued education credits. If the registrant is identified as having not met the minimum license maintenance requirements, notification of evaluation requirements will be sent to the registrant by mail.

APPENDIX A – WRITTEN EXAMINATION SAMPLE QUESTIONS

There are five types of questions:

1. True/False questions.
2. Standard multiple choice. Select the single best answer from the list of options provided.
3. Multiple - multiple choice. Identify all of the correct answers from a list of options provided.
4. Short word answer – subjective. Briefly provide an answer to the question posed.
5. Priority order questions. Organize the appropriate actions into priority order based on the brief case study or situation provided.

Sample Examination Questions

True or False
Patients with circulatory impairment distal to a fracture site should have cold applied to the affected limb to help reduce swelling and pain. True or False

Answer: False

Multiple Choice
To end a radio transmission one should state:

a) 10:4
b) Roger-Wilco
c) Over and out
d) Out

Answer: d

Multiple Multiple Choice
Answer the following multiple choice question by circling all of the numbers that represent options believed to be correct.

The primary survey is composed of:

1. Scene Assessment
2. Level of Consciousness (LOC)
3. Delicate Spine
4. Airway
5. Breathing
6. Circulation
7. Rapid Body Survey (RBS)
8. History
9. Vital signs
10. Reporting of data

Answer: The following numbers should be circled: 2, 3, 4, 5, 6 and 7 (note: alternatively, if a separate answer sheet is provided for the exam, the candidate may be directed to: "please list all of the appropriate numbers on the answer sheet")

Short Word - Subjective
What is the abbreviation for the phrase "Nothing by mouth"?

Answer: NPO

Please list four signs or symptoms that might be observed in a patient suffering a fractured forearm.

Answer: (any four of the following would be appropriate) point tenderness (at the fracture site), redness, bruising (discoloration), swelling, pain, loss of mobility at the wrist, loss of grip strength in the affected limb, numbness, loss of circulation beyond the fracture site (i.e. cold, pulseless limb), abnormal mobility, deformity, shortening, or other acceptable signs and symptoms.

Priority Order
For the following question, number the options in priority order using the space provided in front of each item. Any options identified as inappropriate should be marked with "n/a".

You are the responding EMS crew for an adult patient. The patient is found supine on the floor, unresponsive, apparently as a result of airway obstruction. Nothing has been done for this patient. The treatment is:

Note: The words in italics refer to the findings or results of each action.

7	*assess pulse (pulse found)*
1	*assess LOC (unconscious, not responding)*
2	*assess for possible neck injury (no evidence of injury)*
3	*assess airway and breathing (airway clear, not breathing)*
4	*attempt to ventilate X 2 (no air entry – no chest rise – high BVM resistance)*
5	*start CPR (30:2 large bolus of meat removed)*
n/a	*give up to 15 chest compressions (large bolus of meat removed)*
6	*reassess airway and breathing (airway clear, deep/rapid breathing)*

Alternate Format for Priority Order Question
These questions require the candidate to organize the answers in priority order. Answers should be written on the line provided directly below the question.

For an adult patient found unresponsive, apparently as a result of airway obstruction, your treatment is (note: the information in italics following each action item represents the findings or results of that action item):

- Assess pulse (P) pulse found
- Assess LOC (LOC) unconscious, not responsive
- Assess for possible neck injury (D) no evidence
- Assess airway and breathing (AB) airway clear, not breathing
- Attempt to ventilate X2 (BVM) no air entry, no chest rise, high BVM resistance
- Start CPR (CPR) large bolus of meat removed
- Give up to 15 chest compressions (15) large bolus of meat removed
- Reassess airway and breathing (Reassess AB) airway clear, deep/rapid breathing

Answer: LOC, D, AB, BVM, CPR, Reassess AB, P
(Reference: Heart and Stroke Foundation Canada, BLS for Healthcare Providers, 2006, page 9 and 62)

APPENDIX B - PRACTICAL SCENARIO SAMPLE

Examination Scenario # - Unstable Trauma

PROBLEM: **SCENARIO START TIME:**

DIRECTIONS FOR USE:

Please use a pen to complete this form. Note the last column of brackets, this is for inserting times or the sequence specific items are completed.

A The attendant performed the behaviour in an acceptable manner.

U The attendant did not perform the behaviour in an acceptable manner

If the evaluator did not observe the attendant perform this behaviour or it was not applicable under the circumstances, please indicate so with N/O or N/A at the appropriate item.

	ACCEPTABLE BEHAVIOUR	**A/U**	**TIME**
1	Rescue Scene Evaluation	_____	(___)
2	Wears personal protective equipment	_____	(___)
3	Introduces self & encourages Patient to remain still	_____	(___)
4	Assesses LOC	_____	(___)
5	Assesses for possible spinal injury	_____	(___)
6	INSERT SCENARIO SPECIFIC CRITICAL INTERVENTIONS	_____	(___)
7	Chief Complaint	_____	(___)
8	History of Chief Complaint	_____	(___)
9	Assesses airway	_____	(___)
10	INSERT SCENARIO SPECIFIC CRITICAL INTERVENTIONS	_____	(___)
11	Assesses breathing	_____	(___)
12	INSERT SCENARIO SPECIFIC CRITICAL INTERVENTIONS	_____	(___)
13	Assesses radial pulse	_____	(___)
14	Conducts a Rapid Body Survey	_____	(___)
15	Administers high flow Oxygen	_____	(___)
16	INSERT SCENARIO SPECIFIC CRITICAL INTERVENTIONS OR APPLICABLE PROTOCOLS	_____	(___)
TRANSPORT			
17	Lifts using appropriate technique	_____	(___)
18	Ensures 02 tank secured	_____	(___)
19	Ensures patient comfort, positioning and secured to stretcher (shoulder straps to be used)	_____	(___)
20	Transports appropriately based on patients clinical presentation	_____	(___)
21	Hospital notified - Chief Complaint - Hx of CC - Treatment - Vital Signs - ETA	_____	(___)
HISTORY			

ACCEPTABLE BEHAVIOUR **A/U** **TIME**

22 Investigates history of Chief Complaint further, if required _____ (___)

23 Medical history: _____ (___)

24 Medications and Compliance: _____ (___)

25 Allergies: _____ (___)

VITAL SIGNS

	Event	LOC	Pulse	Resp (SpO2)	Skin	B/P	Pupil	Time	
26									_____
27									_____

28 Vitals taken at times appropriate to patient condition _____

TREATMENT

29 _____ (___)

30 _____ (___)

31 _____ (___)

32 INSERT SCENARIO SPECIFIC TREATMENTS AND PROTOCOLS _____ (___)

33 _____ (___)

34 _____ (___)

35 _____ (___)

PHYSICAL EXAM

36 Inspects & Palpates **head & neck**
- evidence of trauma
- pupil size and reaction
- JVD
- tracheal alignment _____ (___)

37 Exposes, examines and palpates **chest**
- evidence of trauma
- symmetry
- use of accessory muscles _____ (___)

38 Auscultates **lungs**
- air entry
- breath sounds _____ (___)

39 Examines and palpates patient's **back**, if possible without aggravating patient's condition or injuries
- evidence of trauma
- deformity
- auscultates lungs
  - air entry
  - breath sounds _____ (___)

40 Inspects and Palpates **abdomen**
- evidence of trauma
- guarding, rigidity, distension
- masses
- discomfort _____ (___)

ACCEPTABLE BEHAVIOUR		A/U	TIME
41	Inspects and palpates hips and pelvis, checking femoral pulses if applicable - evidence of trauma - deformity - tenderness - stability - checks for incontinence	_____	(___)
42	Inspects & palpates lower extremities - evidence of trauma - distal circulation - sensation - function if possible - pedal pulses	_____	(___)
43	Inspects & palpates upper extremities - evidence of trauma - distal circulation - sensation - function if possible - radial pulses	_____	(___)
IN HOSPITAL			
44	Adequately charts all Tx , Hx, & pertinent information	_____	
45	Hospital Report □ patient's name □ chief complaint □ history of chief complaint □ past/present medical history □ medications □ allergies □ vital signs □ treatment	_____	
ORAL			
46	UP TO FIVE ORAL MAY BE ASKED AT THE END OF EACH CALL, QUESTIONS ARE REFERENCED TO COURSE CONTENT AND MAY NOT NECESSARILY PERTAIN TO THIS SPECIFIC CALL	_____	

APPENDIX C - REMEDIAL FORM SAMPLE

Name: _____ Date: _____ Scenario #: _____

Acceptable ☐ Unacceptable ☐

Full Call ☐ Skill Test ☐ Treatment Plan ☐ Drug Monograph ☐ Other ☐

Remedial Action: If a written assignment is recommended, please outline below what is to be discussed and any pertinent details:

General Comments:

Problem Areas / Written Assignment Subject Matter:

Examiner Signature: _____ Date: _____

This page to accompany the evaluation and the following 2 pages to be given to the applicant.

APPENDIX D - WRITTEN ASSIGNMENT SAMPLE

Name: _____ Date: _____ Scenario #: _____

Written Assignment
Examiners, please check which components apply to the assignment.

PATIENT CARE PLAN	DRUG MONOGRAPH
☐ Patient Presentation	☐ Drug -
☐ Pathophysiology	☐ Action/Usage
☐ Critical Interventions	☐ Pharmacology
☐ Differential Diagnosis	☐ Indications
☐ Drug Profiles/Actions	☐ Contraindications
☐ Applicable Protocols	☐ Precautions
☐ Medical/Surgical Needs	☐ Adverse Effects
	☐ Overdose Symptoms
	☐ Overdose Treatments
	☐ Dosage
☐ Other	☐ Other
Bibliography to be included with every paper (must have a minimum of 3 sources of reference material).	

- Written assignments must be in the form of a “research paper” and will not be acceptable in simple point form outlines.

- All written assignments are to be submitted by email as an attached Word document to emalb@victoria1.gov.bc.ca. Please put your first and last name and ‘Research Paper’ in the subject line. Assignments may also be faxed to 250 952 1222.

- All written assignments must be received by the Licensing Branch within 14 days of the assignment date to be considered valid.

APPENDIX E - WRITTEN ASSIGNMENT GUIDELINES

Cover Page

The following information should appear on the cover page of the completed remedial written assignment:

- Full name
- Telephone number
- Email address
- Date remedial paper was assigned

Background Information

Give a brief (2–3) paragraph background overview of the topic statement and its relevance to accepted practice within license category. Outline expected research accomplishments.

Body of Written Remedial Paper

The body of the paper (2-4 typewritten pages) should contain all the information discovered while analyzing the topic especially in relation to its relevance to accepted practice. Don't be afraid to compare, criticize, and generally leave a personal mark on the paper. If using direct quotations please ensure to include the correct information for the person being quoted. [2] Direct quotations are generally used sparingly. The paper must be fully documented using footnotes or endnotes [1,2,3] indicating all sources of information.

Conclusion

Make a conclusion statement based on the research. Give a brief summary of what has been presented. Emphasize the advantages and disadvantages of the proposed approach, technique, protocol, drug, or practice. Discuss possible future research, and any interesting problem considered.

Bibliography

Provide complete bibliographic information [2,3] for each reference used in the footnotes as well as for general information. When using a computer reference include the complete string or link in order that others may type in the URL and find the same information

Special Notes

When using charts, diagrams or other visual aids in the paper, please ensure that they are clearly labeled and indicate the sources. All papers submitted will be checked and reviewed. Notification of the acceptability of submissions will be made by email. Plagiarism (outright copying or failure to properly credit ideas) will not be tolerated and will result in an incomplete evaluation. Papers may be submitted by fax or by email in Microsoft Word format, and are due 14 days after being assigned.

[1] - http://www.wlv.ac.uk/sls/advice/usingfootnotesandreferences.html
[2] - http://www.lrc.macewan.ca/pdf/writing/footnotes.pdf
[3] - http://www.library.csi.cuny.edu/dept/history/lavender/footnote.html

Email to: emalb@victoria1.gov.bc.ca with “First Name Last Name Research Paper” in the subject line or fax to 250 952 1222.

APPENDIX F - WRITTEN ASSIGNMENT SUBMISSION SAMPLE

EMA LICENSING EXAMINATION

REMEDIAL WRITTEN ASSIGNMENT

SCENARIO #0024A

Joe Applicant
(604) 123 - 4567
J_Applicant@Emergency.com
March 29 2006

This is a written remedial assignment for B.C licensing examination scenario #0024A. I have been asked to write this assignment because I failed to administer glucogel to my patient. I did not administer glucogel because I thought my patient was presenting as a hyperglycemic as opposed to a hypoglycemic. I also had concerns about my patients' airway. Upon researching this topic I have come to learn that diabetes is indeed a very complex disease and that patients experience diabetes in a very subjective way depending on both their own lifestyle choices and the medical direction that they receive. Regardless of my concerns however, the scope of practice for EMA's in B.C. is very straightforward and I have come to realize that administering glucogel to my patient is what I should have done, and what I will do in the future.

My goal upon undertaking research for this paper was to better understand my mistakes, so understanding diabetes and the complications that can arise because of the disease seemed appropriate. I researched patient presentation for both hyper and hypoglycemic patients and I will discuss the differential diagnosis of the two. I looked into the pathophysiology of diabetes mellitus as well as the drugs that are used in patient treatment. With regards to my call I will discuss applicable protocols for an EMA in B.C. as well as the need for early intervention and the importance of critical interventions such as the administration of glucogel. I will also briefly discuss medical and surgical needs of a diabetic patient and provide a drug monograph for glucogel since that is the drug that I failed to administer and is the one drug that a B.C. licensed EMA can administer to a diabetic patient experiencing a hypoglycemic episode.

Patient Presentation

A patient with hyperglycemic emergency may present with the following symptoms [1]:

- Altered mental status, ranging from confusion and disorientation to complete unconsciousness
- Leg cramps
- Hunger and thirst
- Sweet, fruity or acetone-like breath
- Flushed, dry, warm skin
- Rapid weak pulse
- Reports that that the patient has not taken his/her prescribed medications
- Frequent urination

In retrospect my patient did not present with these symptoms. It is also important to note that the onset of a hyperglycemic emergency is gradual and usually takes place over 12 – 48 hours. Onset of a hyperglycemic emergency more rapid and is very dangerous. Patients suffering from hypoglycemia need immediate medical attention. I will discuss treatments later on in this paper.

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[1] - Daniel Limmer et al., Emergency Medical Responder: A Skills Approach, 2nd Canadian ed. (Toronto: Pearson) 234.

Common causes of hyperglycemic emergencies are as follows [2]:

- Infection
- Failure of the patient to take Insulin or to take an insufficient amount
- Eating too much food that contains or produces sugar
- Increased or prolonged stress

It may also be important to note that hyperglycemic emergencies are most common in elderly patients with diabetes and are most likely to occur when triggered by additional illnesses such as a stroke, heart attack, or some kind of infection.

A patient experiencing a hypoglycemic emergency may present with the following symptoms [3]:

- Headache
- Hunger
- Cool, clammy skin
- Rapid Pulse
- Altered mental status ranging from intoxicated appearance to unconsciousness
- Seizures

My patient presented as unconscious with cool clammy, diaphoretic skin and a rapid pulse; classic symptoms of a hypoglycemic episode. I also noticed during my Rapid Body Survey that my patient had a medic alert necklace that indicated he was an Insulin dependent (Type 1) diabetic.

Common causes of hypoglycemic emergencies [4]:

- Skipped meals
- Vomiting
- Strenuous exercise
- Physical stress
- Emotional stress
- Accidental overdose of Insulin
- Extended periods of alcohol consumption (special concern for my patient)

Pathophysiology

In order to understand diabetic emergencies I researched Diabetes Mellitus, commonly called Diabetes. Diabetes comes from the Greek word for siphon, and mellitus comes from the Latin word for sweet. This came about because the diagnostic tests of the day involved tasting the patients' urine, which of course contained excess amounts of sugar. A fun little factoid about diabetes is that in the 17th Century diabetes was known as "The Pissing Evil" [5]. This was because of observations made by physicians of the time who noticed that diabetic patients expelled urine almost as fast as they consumed liquid.

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[2] Ibid.
[3] Limmer, 236.
[4] Limmer, 235.
[5] Alan L. Rubin, M.D. & Ian Blumer, M.D., Diabetes for Canadians for Dummies (Mississauga: John Wiley & Sons, 2004) 3.

Diabetes is “a disease in which there are high blood glucose levels and an increased risk of damage to the body” [6]. There are two main types of Diabetes Mellitus and both of them involve Insulin. If you lack Insulin you are regarded as having Type 1 diabetes. If your body is not able to use Insulin properly you are regarded as having Type 2 diabetes. In general if you have either type of diabetes you experience higher than normal blood glucose levels.

The main organs of the body that are affected by diabetes are the liver and the pancreas. The liver serves as a storage facility for excess glucose. This storage is facilitated by Insulin. When glucose is stored in the liver it is in a form called glycogen. The pancreas contains specialized islet cells called beta cells that produce the hormone insulin.[7]

To summarize Diabetes is a disease that affects glucose levels in the blood. It is important then to understand what glucose does in the body. Glucose is a sugar; Sugar is a carbohydrate, which is one of the body’s three energy sources along with fat and protein. Glucose itself is the fuel that the body uses for quick energy, aiding in muscle movement and acting as a catalyst for many of the body’s important chemical reactions. It is also important to note that glucose is the only fuel that the brain uses directly. This is why patients with both hyper and hypoglycemic emergencies present with altered mental status.

Critical Interventions
The protocol for Diabetic Emergencies for an EMR is as follows.[8]

Indications: Known diabetic patients with a decreased level of consciousness whose history suggests hyperglycemia or hypoglycemia *(this is of special interest to my case because according to protocols I should have administered glucogel regardless of my suspicions of a hyperglycemic episode).

1. Complete primary survey
2. Complete history and vital signs
3. Ensure patient is positioned ¾ prone
4. Administer oral glucose (15ml)
5. Continue with assessment and treatment

Protocols indicate that glucogel should be administered after the patient has been loaded and transport has begun but there is a side note that indicates if time permits glucogel may be administered prior to load and transport. A set of vitals and a history should still be taken before administration and the time, dose, and route (oral) should all be documented.

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[6] Rubin, 10.
[7] Rubin, 24.
[8] Justice Institute of British Columbia. , Emergency Medical Responder: Student Study Guide and Supplemental Readings (New Westminster: Paramedic Academy, 2005) 87.

This is where I made my most crucial error. I stepped outside my role as an EMR and made a judgment call based on my patients' airway (he was drooling heavily and his OPA had already become clogged once) and my suspicions of him being hyperglycemic. I realize now that I should have just given my patient the drug because the action is mandated by my role as a licensed EMR in B.C.

Glucogel

Action/Usage: Absorbed into the blood stream resulting in increased blood glucose levels. As an EMR my protocols indicate that I should orally administer 15ml of Glucogel orally with a tongue depressor. I may re-administer the dose after 3-5 minutes and should always document the time, dose, route, and result.

Pharmacology: Glucogel is classified as a caloric drug that is absorbed into the blood stream via oral absorption. Glucose enters the cells where it provides energy. It is broken down into carbon dioxide and water and excreted via the lungs and kidneys.

Indications: As an EMR I should administer Glucogel to a known diabetic patient with a decreased level of consciousness. *(Special note: I realize now my protocols clearly indicate that regardless of my suspicions I should have administered Glucogel to my patient because he fit the indications)

Contraindications: Glucogel should not be administered to a patient whose airway cannot be maintained.

Precautions: A patient must be positioned in the ¾ prone position before the administration of Glucogel.

Adverse Effects: May cause airway management problems *(special note: when deciding whether or not to administer glucogel I took into consideration that my patient was drooling heavily and I had to clear and reinsert the OPA once after my initial insertion and I had to use suction on my patient twice. My patient was positioned in the recovery position.)

Dosage: As mentioned above an EMR may administer 15ml of glucogel at 3-5 minute intervals.[9]

Importance of Early Intervention

Just like when the brain is denied oxygen the brain can be damaged if it is not receiving adequate amounts of glucose. While it is highly debated exactly how long a patient can be unconscious due to a diabetic emergency before damage is done to the body and brain the fact remains that at some point damage will be done and at some point this damage will be irreversible. Even though I was worried about my patients' airway I still could have administered glucogel as long as I closely monitored the airway for the duration of the trip to the hospital. Looking back I see that that is what I should have done.

[9] JI, 83.

Conclusion

Upon researching this paper I have discovered that diabetes is indeed a very complex disease, or better yet, group of diseases. Each patient experiences diabetes in a unique way. Most importantly though I came to realize that I made a mistake and that I should have given my patient Glucogel.

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Marie McCarren, A Field Guide to Type 2 Diabetes (Virginia: American Diabetes Association, 2004)

Marie McCarren, A Field Guide to Type 1 Diabetes (Virginia: American Diabetes Association, 2004)

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Alan L. Rubin, M.D. & Ian Blumer, M.D., Diabetes for Canadians for Dummies (Mississauga: John Wiley & Sons, 2004)

Daniel Limmer et al., Emergency Medical Responder: A Skills Approach, 2nd Canadian ed. (Toronto: Pearson)

Website: MEDLINEplus Drug Information

- http://www.nlm.nih.gov/medlineplus/druginfo/medmaster/a684058.html
- http://www.nlm.nih.gov/medlineplus/druginfo/medmaster/a682602.html

Website: The Canadian Diabetes Association

- www.diabetes.ca

APPENDIX G - APPLICATION FOR LICENSE

BRITISH COLUMBIA | Ministry of Health

APPLICATION FOR LICENSE

Fax (250 952-1222) or mail completed form to EMA Licensing, PO Box 9625 Stn Prov Govt, Victoria, BC V8W 9P1

Part A: Application Information

Surname	Given Names (Full)	
Street Address or PO Box	Town/City	Postal Code
Telephone	Email Address	Previous Name

Birthdate	Height	Weight	Hair Colour	Eye Colour	Gender ❒ Female ❒ Male

Part B: Employer Information

Employer	Dept Number	Contact Name
Contact Phone #	Department Fax #	Contact Email Address
Street Address or PO Box	Town/City	Postal Code

Part C: License Requested

I hereby apply for a license to practice at the _____ level and agree to abide by the policies and procedures of the Emergency Health Services Commission, the ***Health Emergency Act*** and its regulations, as they apply to my licensed level.

Endorsement ❒ Yes ❒ No If yes, specify type:

❒ Initial License	❒ License Renewal: ❒ Same Level ❒ New Level	License Number:
Applicant's Signature		Date

NOTE: A copy of the certificate indicating successful completion of training from the certifying institute and photograph must be included with all applications for initial license and when applying for a new license level.

Part D: For EMA licensing Branch Use Only

Licensing Exam Date	License Issued	Issuer	License Expiry
Comments:			

Personal information on this form is collected by the EMA Licensing Board under the authority of the *Health Emergency Act* (section 6) and the Emergency Medical Assistant Regulation (sections 2, 3, 4, 5, 6, and 7). This information will be used to issue an EMA license and maintain a permanent register of licensed EMA's. If you have any questions about the collection of this information contact the Registrar at PO Box 9625 Stn Prov Govt, Victoria BC, V8W 9P1, phone: 250 952-1203. This information is protected from unauthorized use and disclosure in accordance with the *Freedom of Information and Protection of Privacy Act* and may be disclosed only in accordance with that Act.

HLTH 2561 Rev. 2005/07/11

APPENDIX H - PATIENT CARE REPORT

BRITISH COLUMBIA | Ministry of Health

EMA LICENSING EVALUATIONS

PATIENT CARE REPORT

RESPONSE #

PATIENT NAME	AGE	DOCTOR	DATE OF EVALUATION (MM / DD / YYYY)

CHIEF COMPLAINT / DESCRIPTION OF INCIDENT

ATTENDANT NAME

DRIVER NAME

TIME CALL DISPATCH _____
TIME AT SCENE _____
TIME TO HOSPITAL _____
TIME AT HOSPITAL _____
TIME CLEAR _____

MECHANISM OF INJURY / HISTORY OF ILLNESS

LEVEL APPLIED FOR

TRAINING INSTITUTION

RELEVANT PAST MEDICAL HISTORY

PHYSICAL EXAM

STATE OF CONSCIOUSNESS _____
H & N _____
CHEST _____
C.V.S. _____
ABD. _____
BACK _____
EXT. _____
C.N.S. _____
BLOOD LOSS _____

MEDICATIONS

ALLERGIES

CARE GIVEN	AIRWAY	OXYGEN	PAIN ASSESSMENT	FRONT	BACK	PUPILS
☐ CONTROL BLEEDING ☐ DRESS WOUND ☐ CPR ☐ AED ☐ SPINAL IMMOBILIZATION ☐ IV THERAPY ☐ PATIENT COMFORT/ REASSURANCE ☐ FRACTURE MGMT	☐ CLEARED ☐ POSITIONED ☐ SUCTIONED ☐ ASSISTED ☐ ORAL AIRWAY	☐ MASK ☐ NON-REBREATHER ☐ BVM ☐ POCKET MASK ☐ NASAL CANNULA _____ OXYGEN LPM				R L ☐ ☐ EQUAL ☐ ☐ REACT ☐ ☐ DILAT. ☐ ☐ CONST. ☐ ☐ FT. L.G. ☐ ☐ LT. L.G. ☐ ☐ OTHER

	GCS				VITAL SIGNS					PROTOCOLS
TIME	E	V	M	TOTAL	PULSE	RESP	SpO^2	BP	SKIN	
								/		
								/		
								/		
								/		
								/		
								/		
								/		
								/		

ADDITIONAL TREATMENTS AND COMMENTS

HLTH 1901 2006/10/03

PATIENT ASSESSMENT GUIDE

RESCUE SCENE EVALUATION

- Personal Protective Equipment
- Environment
- Hazards
- Mechanism of Injury

PRIMARY SURVEY

- LOC
- Delicate Spine
- Airway
- Breathing
- Circulation
- Rapid Body Survey
- O_2

SECONDARY SURVEY

HISTORY

- Chief Complaint
- History of Chief Complaint
- Relevant Medical History
- Medications
- Allergies

VITAL SIGNS

- LOC
- Respiration
- Pulse
- Skin
- BP

HEAD-TO-TOE ASSESSMENT

- Head
- Neck
- Chest
- Breath Sounds
- Bowel Sounds
- Abdomen
- Hips/Pelvis
- Back
- Lower Extremities
- Upper Extremities

HAND-OFF REPORT

- Age
- Chief Complaint
- History of Chief Complaint
- Medical History
- Medications
- Vital Signs
- Allergies
- Relevant Physical Findings
- Treatments/Protocols

FUNCTIONAL INQUIRY

- General
- CNS
- Respiratory
- Cardiac
- GI/GU
- Endocrine
- Muscular/Skeletal

DOCUMENTATION INFORMATION AND COMMON ABBREVIATIONS

GLASGOW COMA SCALE: TOTAL SCORE = /15

Eyes Open	Best Verbal Response	Best Motor Response
4 Spontaneously	5 Oriented	6 Obeys commands
3 To Speech	4 Confused	5 Localizes to pain
2 To Pain	3 Inappropriate words	4 Withdraws from pain
1 No Response	2 Incomprehensible sounds	3 Flexion to pain (decorticate)
	1 No Response	2 Extension to pain (decerebrate)
A Alert		1 No Response
V Verbal		
P Pain		
U Unresponsive		

PAIN ASSESSMENT

P Position	L Location
Q Quality	O Onset
R Radiation	T Type of pain
S Severity	A Associated/Aggravated symptoms
T Timing	R Relieving/Radiating
	P Precipitating event

MEDICAL ASSESSMENT

- S Signs & Symptoms
- A Allergies
- M Medications
- P Previous Hx
- L Last Oral Intake
- E Events Precipitating

Abdomen	Abd
Abdomen pain	Abd pn
As needed	prn
Automatic External Defibrillator	AED
Alcohol	ETOH
Bag-Valve-Mask	BVM
Basic Life Support	BLS
Blood Pressure	BP
Body Surface Area	BSA
Cardiopulmonary Resuscitation	CPR
Cardiovascular	CV
Central Nervous System	CNS
Chief Complaint	CC
Chest Pain	CP
Complains of	c/o
Chronic Obstructive Pulmonary Disease	COPD
Congestive Heart Failure	CHF
Coronary Artery Disease	CAD
Dead on Arrival	DOA
Decreased	↓
Delirium Tremens	DTs
Ear, Nose, and Throat	ENT
Equal	=
Estimated time of arrival	ETA
Female	♀
Foreign body obstruction	FBO
Gastrointestinal	GI
Gunshot Wound	GSW
History	Hx
Hypertension	HTN
Immediately	Stat
Increased	↑
Insulin Dependent Diabetic Mellitus	IDDM
Left Lower Quadrant	LLQ
Left Upper Quadrant	LUQ
Less than	<
Level of Consciousness	LOC
Male	♂
Mass Casualty Incident	MCI
Medications	Med
Motor Vehicle Accident	MVA
More than	>
Non-Insulin dependent diabetes mellitus	NIDDM
Nonrebreather mask	NRM
Nothing by mouth	NPO
Obstetrical/gynaecological	OB/GYN
Oropharyngeal airway	OPA
Overdose	OD
Oxygen	O2
Pain	pn
Palpation	Palp
Patient	Pt
Pulse	P
Range of Motion	ROM
Respirations	R
Right Lower Quadrant	RLQ
Right Upper Quadrant	RUQ
Rule Out	R/O
Short of Breath	SOB
Signs and Symptoms	S/S
Temperature	T
Transient Ischemic Attack	TIA
Treatment	Tx
Times	X
Unconscious	unc
Vital Signs	VS
Year-old	y/o

APPENDIX I - PRACTICAL EXAMINATION EQUIPMENT LIST

Equipment list per exam room unless otherwise noted:

- O2 Tank, portable
- O2 Regulator
- Oxygen Masks with associated tubing (Adult, paediatric, non rebreather, nasal cannula, nebulizer)
- Entonox (empty bottles only)
- Entonox regulator including bite stick and mask delivery devices (reusable)
- Suction Unit with tubing and Yankauer tip (electric portable Laerdal type
- Traction Splint (Sager, Hare or similar)
- Spine Board (functional and safe for patient use)
- Clamshell (Robertson Orthopaedic Stretcher) (functional and safe for patient use)
- Spider Straps (or similar board loc device)
- 2 – 12" straps with buckles (sufficient for spine board immobilization)
- 4 – 5lb Sandbags
- Wooden Splints (1 padded femur, 2 padded tib/fib)
- Blanket x 2 (standard size, hypoallergenic preferred)
- Mat/Carpet (minimum 5' X 8')
- Clipboard
- Adult Torso Mannequin (Laerdal or similar with ability to be used to demonstrate Canadian Heart and Stroke CPR and AED simulations)
- Baby Mannequin (Laerdal or similar with ability to be used to demonstrate Canadian Heart and Stroke CPR simulations)
- AED Trainer - May be a non functional prompt (i.e. a trainer model)
- Standard Obstetric Kit (1 only for each location) reusable, sterility simulated
- 7 Level Stretcher (Ferno Washington Type 30C or similar functional and safe for patient use)
- 1 box each large medium and small latex exam gloves

Drug Kit

- 1 small bottle labelled ASA (simulated tablets, no actual drugs required)
- 1 small spray bottle labelled Nitro Spray (simulated, no actual drugs required)

Jump Bag

- BVM with reservoir and O2 tubing (Adult and Infant) reusable
- 1 sphygmomanometer with adult and child cuffs (fully functional)
- 1 stethoscope (fully functional)
- 1 Pulse Oxymeter - May be a non functional prompt (i.e. a trainer model)
- OPA set (sizes 00, 0, 1 – 6 (metric 5 – 12)
- Handheld suction unit with large tip
- Pocket mask with one way valve and O2 port
- 1 litre sterile saline or H20
- 1 Burn Kit (sheet, pillow case, OR mask, gloves) reusable, sterility simulated
- 2 - 12" X 12" polygauze type dressings (burn use) reusable, sterility simulated
- 1 - 18" X 18" polygauze type dressings (burn use) reusable, sterility simulated
- 1 - 24" X 24" polygauze type dressings (burn use) reusable, sterility simulated
- 1 sterilizing hand cleaner (alcare, isogel type)
- 2 pressure dressings (reusable) sterility simulated
- 2 - 8" X 10" abdominal pads (reusable) sterility simulated
- 2 - 6" X 8" abdominal pads (reusable) sterility simulated
- 1 - 10" X 30" trauma dressing (reusable) sterility simulated

- 6 - 3” cling or crepe elastic dressing (reusable)
- 1 small assortment of minor bandages (reusable) sterility simulated
- 2 large sealable plastic bags (Ziplock Freezer type)
- 1 -1” roll cloth tape
- 1 -1” roll hypoallergenic tape
- 1 package 4” X 4” gauze (reusable) sterility simulated
- 6 - 3” X 5” non stick (telfa type) pads (reusable) sterility simulated
- 1 roll 3” or 4 “ Esmarch type bandage
- 6 - cloth triangular bandages
- 2 - hot packs
- 2 - cold packs
- 4 - flexible metal splints (SAM or other expandable reusable)
- 6 - Speed Straps (Zap Straps) (3 medium and 3 long)
- 2 tongue depressors
- 2 glucose packs (simulated, no actual drugs required)
- 1 glucometer (prop only, no stylettes or test strips)
- 1 pair scissors sufficient to cut clothing
- 1 pen light
- Hard Collar Kit
- 2 adjustable size collars (Laerdal type or similar)
- Headbed (reusable)
- Padding
- 1 roll 1” fibreglass tape or similar
- head blocking device (Sam splint, Ferno Washington or other similar)

Additional PCP and ACP Items

- 4 small (250cc or 500 cc bags normal saline, 2 of each labeled D-10 w)
- 4 standard adult administration sets
- 10 Opsite dressings
- 1 package 2” X 2” guaze pads
- 10 2” X 2” sterile guaze pads
- 1 roll 1” hypoallergenic tape
- 1 functional IV arm for demonstrating IV starts
- IV Normal Saline
- Dextose 10%
- Ventolin (simulated w/ H2O)
- Glucagon (simulated, no actual drugs required)
- Narcan (simulated multidose vial w/ H2O)
- Epinephrine (simulated multidose vial w/ H2O)
- Benadryl (simulated tablets, no actual drugs required)
- Thiamine (Betaxin)

Additional ACP Items

- Lifepack 12
- Rhythm simulator
- Pacing simulator
- Intubatable mannequin (Code Kelly or similar item)
- Baby intubatable mannequin
- Pediatric intubation kit
- Adult intubation kit
- ACP drug box (Drugs itemized below)
    - Adenosine
    - Calcium Chloride

- Dextrose 50%
- Dimenhydrinate (Gravol)
- Furosemide (Lasix)
- Heparin
- Ipratropium Bromide (Atrovent)
- Lidocaine HCL
- Morphone Sulphate
- Procainamide (Pronestyl)
- Acetaminophen
- Atropine Sulphate
- Magnesium Sulphate
- Midazolam (versed)
- Sodium Bicarbondate

APPENDIX J – FEE SUMMARY

For all Licensing evaluations listed below, please carefully review the "*Applicant Guide to EMA Licensing Examinations*' booklet for detailed information on the exam process. There is no fee for remedial written or practical exams.

EMR – All Applicants – Licensing Evaluations will be comprised of both written and practical components.		
Written exam fee $50	Practical exam fee $400	No fee for license issue on successful completion of all evaluation components
PCP – Applicants having taken training within BC – Licensing evaluations will be comprised of practical components only and will include evaluation of IV skills.		
Student License fee $50	Practical exam fee $400	No fee for license issue on successful completion of all evaluation components
PCP – Applicants having taken training outside BC (OPA) – Licensing evaluation requirements will be outlined to you in a letter from this office on receipt and review of all required OPA documentation.		
Written exam fee $50	Practical exam fee $400	No fee for License issue on successful completion of all evaluation components
IV Endorsement - Applicants who were previously licensed at the PCP level without the IV endorsement or who have had the endorsement suspended for 12 months or greater and have completed IV Therapy training.		
Written exam fee $50	(No Practical exam required)	No fee for endorsement on successful completion of all evaluation requirements
ACP in Province - All Applicants		
Student License fee $50	Practical exam fee $500	No fee for any of the non student Licenses, and no fee for the full ACP license issued on successful completion of all evaluation components
ACP Out of Province – (OPA) - Licensing evaluations will be comprised of a written exam for all applicants. Whether or not there is the need for a practical evaluation will be determined and outlined to you in a letter from this office on receipt and review of all required OPA documentation. Applicants will be expected to take part in the BCAS ACP Residency Program.		
Written exam fee $50	If practical exam is required Fee = $500 →	No fee for any of the non student licenses, and no fee for the full ACP license issued on successful completion of the ACP Residency Program
	If no Practical exam required →	Non Student License fee = $50 (one time only) and, full ACP License fee = $50 issued on successful completion of the ACP Residency Program
License Maintenance – required if annual CE and Patient Contact requirements are not met. Exam requirements will be outlined in a letter from this office. There are firm timelines for completion of each component to avoid license suspension.		
Written Exam fee $50 (all levels)	Practical Exam fee (if required) EMR / PCP = $400 ACP = $500	Please carefully review the License Maintenance section of the EMA Licensing intranet website for details on the License Maintenance exam process, timelines and requirements.
License renewal, replacement of lost/stolen/destroyed license		
License issue fee = $50	All EMAs are required to carry with them their valid EMA license in order to function as a paramedic.	

APPENDIX K – APPROVED PROCTORS IN BC

Written exams are proctored in your community. Alternate proctors will not be approved in communities that have a Government Agent.

Approved Proctors in BC:

- Service BC Government Agents (Excluding Maple Ridge):
  http://www.governmentagents.gov.bc.ca/locations/map.htm
- BCAS Human Resources offices
- Surrey Ocean Park Branch of the Surrey Public Library
  Semiamoo Branch of the Surrey Public Library
- EMA Licensing Branch (Victoria)
- In communities that do not have a Government Agent:
  - Alert Bay — Village of Alert Bay
  - Bella Bella — RCMP Bella Bella
  - Gabriola Island — Gabriola Island Local Trustee (weekends only)
  - Kelowna — Okanagan College Deans Office Industrial Trades
  - Masset — Village of Masset
  - Port Alice — Village of Port Alice
  - Queen Charlotte City — Northwest Community College
  - Sandspit — A.L. Mathers School
  - Tahsis — Village of Tahsis
  - Texada Island — Gillies Bay FD