



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

1. Last Name First Name M. Initial
Mailing Address City/Town State Zip
(Home Address if Different) Home Phone #
Date of Birth Driver's License # Social Security No.

2. HIGHEST EDUCATION ATTAINED (Circle)
Elementary High School College
1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5+
3. CURENT STUDENT
High School Other

4. CERTIFICATION APPLIED FOR
INITIAL CERT.
RECERT. (EMT/MRT #)
CURRENTLY CERT. YES NO
EXECUTIVE/MANAGEMENT
CERTIFICATION #:
4.1 MRT
EMT
EMT-I
6. PROVIDER INFORAMTION
(If presently Affiliated)
1.
2.
6.1 JOB ASSIGNMENT
ATTENDANT DRIVER
DISPATCHER OTHER
7. OCCUPATION/PROFESSION
ATTORNEY
EMS PROFESSIONAL
FARMER
FIREFIGHTER
INDUSTRIAL/BUSINESS
LAW ENFORCEMENT
NURSE
PHYSICIAN
TEACHER
OTHER

5. SPECIAL APPLICANTS
CHALLENGE (STATE)
EXAM BY REQUEST
LEGAL REC. (STATE)
6.2 JOB ASSIGNMENT
FULL-TIME (Paid) VOLUNTEER
PART-TIME (Paid) OTHER

(FOR COURSE COORDINATOR ONLY)

8. EDUCATIONAL COURSE RECORD
()
COURSE TITLE & APPROVAL #
BEGAN (Mo. & Yr) ENDED (Mo. & Yr)
COURSE LOCATION
CITY/TOWN STATE
NAME OF EMS-I/ADMINISTRATIVE COORDINATOR
EMS-I #

(FOR OEMS USE ONLY)

TRANSFER DATE
WRITTEN EXAM #1 #2
FAIL NOTIFICATION
RETAKE FAIL NOTIFICATION
OTHER FAIL NOTIFICATION
CERTIFICATION ISSUED
REMARKS

9. BASIC LIFE SUPPORT CERTIFICATION LEVELS

9.1 COURSE COORDINATOR STATEMENT

I certify that the candidate named on the reverse side has successfully completed the course requirements and is eligible to take the state certification exams.

SIGNATURE OF COURSE COORDINATOR: _____ DATE: _____

EMS-I CERTIFICATION NUMBER: _____

9.2 APPLICANT STATEMENT

I hereby certify that I have not been convicted of a crime involving moral turpitude within the past three years, nor am I addicted to the use of drugs or alcohol. The information on this application is true and correct.

SIGNATURE OF APPLICANT: _____ DATE: _____

10. MOBILE INTENSIVE CARE CERTIFICATION LEVELS

10.1 MEDICAL DIRECTOR/ADMINISTRATIVE COORDINATOR STATEMENT

The candidate named on the reverse side, having completed successfully all education requirements that have been set forth by the Office of Emergency Medical Services and institution has been evaluated and found to be physically and mentally competent to perform the required skills for this level of certification.

I certify that this candidate is eligible to take State Certification Examinations.

Medical Director

Administrative Coordinator

Date ____/____/____

Date: ____/____/____

10.2 MOBILE INTENSIVE CARE APPLICANT STATEMENT

I hereby certify that I have not been convicted of a crime involving moral turpitude within the last three years nor am I addicted to the use of drugs or alcohol. The information on this applicant is true and correct.

SIGNATURE OF APPLICANT: _____ DATE: ____/____/____