

Connecticut Department of Public Health
Verification of EMS License/Certification Status

Applicant-Complete the top portion of this form and forward it to each state where you have been licensed, certified, or registered as an emergency medical services provider or to the National Registry of Emergency Medical Technicians (make copies as necessary).

Section 1: Applicant information

Last Name: First Name: MI: SSN:

Address: No. & Street City State Zip Code

Original License/Certification number Date Issued (in the state to which the form is being forwarded)

Type: First Responder (MRT) Emergency Medical Technician Emergency Medical Technician-Intermediate

I hereby authorize the to furnish the Connecticut Department of Public Health the information requested below.

Signature Date

DO NOT WRITE BELOW THIS LINE—FOR VERIFYING AGENCY USE ONLY

Section 2: Verifying Organization: Please complete this section as completely as possible. The information you provide will assist in the review of this individual's eligibility for Connecticut EMS certification.

I certify that the above named individual was issued license/certificate number to practice as a effective

Certification Issue Date: Certification Expiration Date:

What examination does your agency currently require for purposes of certification?

National Registry Professional Examination Service State Board Examination Other:

Does your agency currently require successful completion of a training program adhering to the United States Department of Transportation National Highway Traffic Safety Administration National Standard Curriculum? YES NO

If No, please provide a brief description of the requirements this individual completed for purposes of certification.

Has this individual ever been subject to disciplinary action of any type or is this individual currently the subject of a pending disciplinary action or unresolved complaint? YES NO. If yes, please forward all publicly disclosable information regarding the individual's status and the basis for same. Please advise this office if you require a consent for release of this information from the applicant.

Signed: Title:

Name of Agency:

Address:

City/State/Zip: Telephone Number:

PLEASE RETURN THIS FORM DIRECTLY TO: Department of Public Health EMS Certification 410 Capitol Ave., MS #12EMS P.O. Box 340308 Hartford, CT 06134-0308 (phone) (860) 509-7975 (fax) (860) 509-7987