



**Rhode Island Department of Health
Division of Emergency Medical Services**

3 Capitol Hill , Room 103
Providence, RI 02908-5097

Application For

***License as an
Emergency Medical Technician***

Select the level of EMT Licensure you are applying for (check one):

EMT

EMT-Cardiac (EMT-C)

Paramedic

Applicant - Print Name (First/MI/Last)

Do Not Hand Deliver - Application Must Be Mailed

FOR DEPARTMENT OF HEALTH USE ONLY

Approved

Denied

Date _____

By _____

EMT# _____

Expiration Date: _____

Phone: (401) 222-2401

TTY/TDD: (800) 745-5555

Fax: (401) 222-3352

GENERAL INFORMATION

1. Requirements for EMT licensure are established by the Rules and Regulations Relating to Emergency Medical Services (R23-4.1EMS), available through the Division of EMS website at <http://www.health.ri.gov>
2. EMT licensure can be denied pursuant to the provisions of the Rules and Regulations Relating to Emergency Medical Services (R23.4.1EMS). False/incorrect statements or documents may be considered sufficient cause to deny or revoke a license as an EMT in Rhode Island and may result in additional penalties as determined by law. The Department may conduct random application audits, requiring the EMT applicant to file proof of completion of the above training requirements for renewal.
3. Should you have any questions regarding the EMT license requirements or completion of the application form, contact the Division of Emergency Medical Services at (401) 222-2401.

➔ **PLEASE NOTE: This application form (dated 01/31/2011) supplants all previous versions. Prior versions of the application will not be accepted or processed.**

APPLICATION INSTRUCTIONS

1. Complete all application materials as instructed. Please answer all questions. Incomplete questions or incomplete applications will not be processed. Please mark "NA" on questions that are Not Applicable.
2. Do not detach any full pages from this booklet.
3. Please use a **ball-point type pen** when completing these forms.
4. Sign the application and return it with the required fee(s). Do not submit the application without all applicable information, documentation and fee(s).

5. Mail the completed application to:
Rhode Island Department of Health
Division of Emergency Medical Services
Room 103, 3 Capitol Hill
Providence RI 02908-5097

Please note: Extra postage will be required.

6. Faxed applications WILL NOT be accepted.

PERSONAL CHECKS WILL NOT BE ACCEPTED. PAYMENT MUST BE A (CASHIER'S CHECK OR MONEY ORDER)

REQUIRED DOCUMENTATION

- | | |
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| <p><input type="checkbox"/> 1. ALL applicants at any level must submit an ORIGINAL Bureau of Criminal Identification (BCI) report. Rhode Island residents shall obtain this information from the RI Attorney General's Office, 150 South Main Street, Providence, RI 02903. Tel. (401) 421-5268. Out-of-state applicants should obtain their full BCI report from their state of residence. If an offense occurred in another state, a full BCI will also be required from the state in which the offense occurred.</p> <p><input type="checkbox"/> 2. Photostatic copy (front and back) of a current - signed Healthcare Provider level or equivalent cardiopulmonary resuscitation (CPR) card eg. (American Heart Association Healthcare Provider, American Red Cross Professional Rescuer, American Safety and Health Institute CPRPRO, Medic First Aid BLSPRO, or National Safety Council Professional Rescuer CPR). This card must be signed.</p> <p><input type="checkbox"/> 3. For First-Time Applicants - photostatic copy of High School Diploma or GED</p> <p><input type="checkbox"/> 4. Photostatic copy of diploma or certificate from the sponsoring agency/school verifying completion of the EMT training program specific to the level of licensure application.</p> | <p><input type="checkbox"/> 5. EMT and Paramedic Applicants - photostatic copy of current NREMT Registration</p> <p style="text-align: center;"><u>Out of State Applicants Complete 6-10</u></p> <p><input type="checkbox"/> 6. Documentation of EOA-PASG (MAST) training (Out of State applicants only)</p> <p><input type="checkbox"/> 7. Photostatic copy of EMT license from a state other than Rhode Island, if applicable.</p> <p><input type="checkbox"/> 8. Photostatic copy of current registration with the National Registry of Emergency Medical Technicians if applying for EMT or Paramedic By Endorsement.</p> <p><input type="checkbox"/> 9. Interstate Verification Form completed by each state (other than Rhode Island) in which the applicant has been licensed and/or trained as an EMT (if applicable).</p> <p><input type="checkbox"/> 10. Out-of-state applicants should obtain their full BCI report from their state of residence.</p> |
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IMPORTANT: Licensure is an individual responsibility and NOT the responsibility of your employer or supervisor.

17. Affidavit of Applicant

Complete this section and sign.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a Emergency Medical Technician in the State of Rhode Island.

I understand that my records are protected under the Federal and State Regulations governing Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the law. I understand that my records are protected under the Federal and State Laws and Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Division of Emergency Medical Services of any change in the answers to these questions after this application and this affidavit is signed.

Signature of Applicant

Date of Signature (MM/DD/YY)



Substitute forms are not acceptable - Copy this form as needed.

Rhode Island Division of Emergency Medical Services

Room 103, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-2401

INTERSTATE VERIFICATION FORM - ORIGINAL AND ALL OTHER STATES OF LICENSURE

Applicant Instructions: Complete the top portion of this form and forward it to each state or territory where you have been trained and/or licensed, certified or registered as an Emergency Medical Services provider (make copies as necessary).

I am applying for a license to practice as an Emergency Medical Technician in the State of Rhode Island. The Rhode Island Division of Emergency Medical Services requires that the following form be completed by the jurisdiction in which I obtained my original training and/or license and all other states of licensure. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Division of Emergency Medical Services at the above address.

Print/Type Full Name	Signature	Date
Previous Names Used	Social Security Number	Date of Birth
Address	City	State
		Zipcode
Contact Phone Number and Email address	License Number	Date Issued

THIS SECTION TO BE COMPLETED BY THE EMS LICENSING AGENCY

EMT Program Completed:	Location:	Graduation Date:
Licensed by Examination? <input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant has completed and passed both Written & Practical Exam: <input type="checkbox"/> Yes <input type="checkbox"/> No	
License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed	Original Date Issued:	Expiration Date:

- Questions:**
- Has this licensee ever been investigated by your office? Yes No
 - Has this licensee incurred any disciplinary proceedings in your state, or is any action pending? Yes No
 - Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? Yes No
 - Do you know of any information that may discredit this person? Yes No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Agency order, complaint, etc.).

- Does this certification include use of: 1. Anti-shock Trousers (MAST)? Yes No 2. Esophageal Obturator Airway? Yes No
- Has this applicant completed course final exam or state practical exam to include the following practical skills: Airway Management, Traction Splint, Kendrick Extrication Device (KED) or Short Board, Long Spine Board, MAST, Patient Assessment? Yes No

Certification issued based on: Completion of a course in compliance with the U.S. Department of Transportation EMT National Standard Curriculum

Reciprocity from the State of _____

Reciprocity from the National Registry of Emergency Medical Technicians

Location of Course (Include printout of initial EMT course): _____ Date that Certificate was issued: _____

Certification:

Signature	Date	Please Affix Board Seal Here
Type or Print Name	Title	

Full Name of Licensing Agency