Rhode Island Department of Health
Division of Health Services Regulation
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-Basic (EMT-B)** ☐ **EMT-Cardiac (EMT-C)** ☐ **EMT-Paramedic (EMT-P)**

Applicant - Print Name (First/MI/Last)

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**

Revised 05/17/2011 jcp

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

☐ 1. **ALL** applicants at any level must submit a FULL Bureau of Criminal Identification (BCI) report. Rhode Island residents may 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 occured in another state, a full BCI will also be required from the state in which the offense occurred.

☐ 2. Photostatic copy (front and back) of a **current - signed** Healthcare Provider level or equivalent cardiopulmonary resuscitation (CPR) card (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.**

☐ 3. **For First-Time Applicants -** photostatic copy of High School Diploma or GED

☐ 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.

☐ 5. **EMT-Paramedic Applicants -** photostatic copy of current NREMT Registration

Out of State Applicants

☐ 1. Documentation of EOA-PASG (MAST) training (Out of State applicants only)

☐ 2. Photostatic copy of EMT license from a state other than Rhode Island, if applicable.

☐ 3. Photostatic copy of current registration with the National Registry of Emergency Medical Technicians if applying for EMT-Basic By Endorsement.

☐ 4. 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).

☐ 5. Out-of-state applicants should obtain their full BCI report **from their state of residence**.

IMPORTANT: Licensure is an individual responsibility and NOT the responsibilty of your employer or supervisor.

State of Rhode Island
Division of Emergency Medical Services

Application for License as an Emergency Medical Technician

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your license and reported to those who inquire about your license. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

Mandatory Information

3. Gender

☐ Male ☐ Female

4. Date of Birth

Month Day Year

5. Home Address

It is your responsibility to notify the EMS Office of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S.

Postal Code, If NOT U.S.

Home Phone

Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Rhode Island License

Please provide information concerning your previous licensure in the State of Rhode Island, if applicable.

Have you **ever** been licensed as an EMT in Rhode Island? ☐ Yes ☐ No

If the answer to this question is ***"yes"***, provide license number, and if applicable, enter all other state abbreviation(s) of EMT licenses you hold or may have held in Question 7.

Rhode Island License Number EMT

License Number

7. Other State Licensure

List all states or countries in which you are now or ever have been licensed to practice as an EMT.

YOU must send a copy of the Interstate Verification Form to each entity (see page 10).

State/Country:			State/Country:		
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive

8. EMT Training Program Information

Please enter the Last Name and License Number of the Instructor-Coordinator who provided you with your EMT training. Also, provide the name of the Sponsoring Agency, the dates of the training program and the Course Approval Number.

Last Name of Instructor-Coordinator

IC

License Number of Instructor-Coordinator

Note: The EMS Instructor-Coordinator's License Number is the same as their RI EMT License Number

Sponsoring Agency

Month Day Year

Month Day Year

–

Course Approval Number

Note: The Course Approval Number was given to you at the start of your training course. It may be obtained by contacting the EMS Licensed Instructor-Coordinator who provided your training.

9. Disaster Availability

I am interested in becoming a volunteer emergency responder during a disaster or state of emergency. ☐ Yes ☐ No

10. Rhode Island EMS/Dept/ Service Affiliation

Please list only ONE affiliation. If you have no affiliation, please mark question as NA.

Rhode Island EMS Department/Service Affiliation

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Business Phone Extension Business Fax

11. Dept/Service Affiliation Verification

To be completed by Chief of department or service.

I hereby certify that _____ is a bonafide member of my EMS Service/Department and that said affiliation is true and accurate.

Printed Name of Chief

_____

Signature of Chief

_____

Date of Signature

12. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending? ☐ Yes ☐ No

Abbreviation of State and Conviction[1] (e.g. CA - Illegal Possession of a Controlled Substance):

	Month	Year

ALL applicants at any level must submit a **FULL Bureau of Criminal Identification (BCI) report.** Rhode Island residents may 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 occured in another state, a full BCI will also be required from the state in which the offense occurred.

13. Disciplinary Questions

Check either Yes or No for each question.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are formal charges pending? ☐ Yes ☐ No
2. Have you ever been denied a Health Professional license, certificate registration or permit in any state? ☐ Yes ☐ No
3. Has an EMS Department/Service, for any reason, ever suspended, restricted, or placed on probation your EMS privilege to practice? ☐ Yes ☐ No

Note: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper.

14. National Registration

Are you currently certified by the National Registry of Emergency Medical Technicians (NREMT)? ☐ Yes ☐ No

If the answer to this question is "yes", please provide certification information below:

NREMT#: _____ Expiration Date: ____ (Month) ____ (Day) ____ (Year)

15. Payment of Fees

Select appropriate fees and enclose payment as instructed.

PERSONAL CHECKS ARE NOT ACCEPTED

CASHIER'S CHECK OR MONEY ORDERS ONLY.

☐ Application Fee **$90.00**

☐ Examination Fee **$90.00**

Please select these two options when submitting your initial application for an EMT-Basic or EMT-Cardiac license.

☐ Re-examination Fee **$60.00**

TOTAL ENCLOSED $ _____ **.00**

☐ I am exempt from application/examination fees (see below, must complete Items #10 and #11)

EXEMPTIONS: Per Section 23-4.1-10, the following categories of Rhode Island Licensed EMS Providers are considered "Exempt":

- City or town services, vehicles and their employees.
- Volunteer or not-for-profit services, vehicles and individuals providing services therein.
- Fire district service, vehicles and individuals providing services therein.

Required fees must accompany the EMT application.
PERSONAL CHECKS ARE NOT ACCEPTED
Fees must be made payable to the General Treasurer, State of Rhode Island and must be either a Cashier's Check or Money Order.
PLEASE NOTE: ALL FEES ARE NON-REFUNDABLE

16. Taxpayer Status/Identity Verification

☐ I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all all taxed owed.

☐ I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the tax administrator.

☐ I am currently pursuing administrative review of taxes owed to the state.

☐ I am in federal bankrupcy. (Case # _____)

☐ I am in state receivership. (Case # _____)

☐ I have been discharged from bankrupcy. (Case # _____)

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a liceense as mandated by state law (RIGL 5-76) except as noted. In order to verifty that the state is not owed taxes, licensees are required to provide their Social Securtiy Number, or Federal Tax Identification Number (for businesses) as appropriate. These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a liense.

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? ☐ Yes ☐ No

Applicant has completed and passed both Written & Practical Exam: ☐ Yes ☐ No

License Status: ☐ Active ☐ Inactive ☐ Lapsed	Original Date Issued:	Expiration Date:

Questions:

1. Has this licensee ever been investigated by your office? ☐ Yes ☐ No

2. Has this licensee incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No

3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No

4. 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.).

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5. Does this certification include use of: **1**. Anti-shock Trousers (MAST)? ☐ Yes ☐ No **2.** Esophageal Obturator Airway? ☐ Yes ☐ No

6. 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 couse in compliance with the U.S. Department ofTransportation 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 _____

Type or Print Name _____ Title _____

Full Name of Licensing Agency _____

Please Affix Board Seal Here

Please return directly to EMS at the above address.