STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Office of Emergency Medical Services

VERIFICATION OF PARAMEDIC LICENSURE

TO BE COMPLETED BY APPLICANT

Applicant - complete the top portion of this form and forward it to each state where you have been licensed, certified or registered as a paramedic. (make copies as necessary)

Last Name: _____ First Name: _____ MI: ____ Maiden Name:_____

Address: _____City:_____State:_____Zip:_____

Original License number: _____ Date Issued: _____ SSN#: _____DOB: _____
(in the state to which the form is being forwarded)

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

Signature _____ **Date** _____

TO BE COMPLETED BY LICENSING AGENCY ONLY

This is to certify that the above named individual was issued number _____ as a paramedic.

Issue Date: _____ Expiration Date:_____

Basis for licensure in your state: ☐ Examination ☐ Endorsement (Please List States(s))

_____

Current Status: ☐ Active ☐ Inactive ☐ Lapsed

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

☐ National Registry ☐ Professional Examination Service ☐ State Board Examination ☐ Other: _____

Has this individual completed a training program adhering to the most current EMS Education Guidelines as promulgated by the US Department of Transportation? ☐ **Yes** ☐ **No**. If no, please provide a brief description of the requirements this individual completed for purposes of licensure.

Has this individual ever been the subject of a pending disciplinary action of any type or is this individual currently the subject of pending disciplinary action or unresolved complaint? ☐ **Yes** ☐ **No**. If yes, please forward all publicly disclosable information regarding the individual's status and basis for same.

Signed: _____ Title: _____

State: _____ Date: _____

Telephone Number: _____ Email address: _____

Please complete and return directly via email to dph.emslicensing@ct.gov (*preferred method*), via fax at 860-920-3142 or via mail to:

Click to Print

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DEPARTMENT OF PUBLIC HEALTH
PARAMEDIC LICENSURE
410 CAPITOL AVE., **MS# 12EMS**
P.O. BOX 340308
HARTFORD, CT 06134-0308
860-509-7975 x1 (o)

*For all fields to work properly, please download form to computer and open with Adobe Acrobat

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