



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



REQUEST TO CHANGE FROM AEMT TO EMT CERTIFICATION

Print/Type the information requested:

Certification provider number: _____ Last 4 digits of your SSN: XXX-XX-_____

Last Name: _____ First Name: _____ MI: _____

Primary phone number: _____

Email address: _____

Street Address: _____

Street Address 2: _____ Apt/Suite: _____

City: _____ State: _____ Postal Code: _____

By signing below, I attest that I no longer wish to maintain my Advanced Emergency Medical Technician Certification and would like to have my Emergency Medical Technician Basic Certification reinstated.

Signature: _____

Date: _____

Please return completed form by clicking on the [Submit](#) button.

Forms can also be sent via [fax](#) or [mail](#) to the below address:

Connecticut Department of Public Health
410 Capitol Ave., MS# 12 EMS
P.O. Box 340308
Hartford, CT 06134
Fax: 860-920-3142
Phone: 860-509-7975 x1
dph.emslicensing@ct.gov