



# 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: \_\_\_\_\_  
(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](mailto:dph.emslicensing@ct.gov) (preferred method), via fax at 860-920-3142 or via mail to:

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