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

OFFICE OF EMERGENCY MEDICAL SERVICES

VERIFICATION OF EMS LICENSE/CERTIFICATION FORM

TO BE COMPLETED BY APPLICANT ONLY

Applicant- Complete the top portion of this form and forward it to each state or territory (not applicable to the National Registry) where you have been licensed, certified, or registered as a emergency medical services provider (make copies as necessary).

Section 1: Applicant information

Last Name: _____ First Name: _____ MI: ____ SSN: _____
Address: _____ City/State/Zip: _____
Original License/Certification number _____ Date issued: _____
(in the state to which the form is being forwarded)

Type: ☐ Emergency Medical Responder ☐ Emergency Medical Technician ☐ Advanced Emergency Medical Technician

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

Signature_____ **Date** _____

TO BE COMPLETED BY VERIFYING AGENCY ONLY

Section 2: Verifying Organization: Please complete this section as completely as possible. The information you provide will assist in the review of this individual's eligibility for Connecticut EMS certification.

I certify that the above named individual was issued license/certificate number: _____ to practice as an _____ effective _____
Certification Expiration Date: _____

What was the basis for licensure/certification/registration in your state? ☐ Examination ☐ Endorsement (endorsement, from another state)? _____

What examination does your agency currently require for purposes of certification?
☐ National Registry ☐ Professional Examination Service ☐ State Board Examination ☐ Other: _____
_____

Does your agency currently require successful completion of a training program adhering to the United States Department of Transportation, National Highway Traffic Safety Administration EMS Education Standards? ☐ YES ☐ NO. **If no**, please provide a brief description of the requirements this individual completed for purposes of certification.

Has this individual ever been subject to disciplinary action of any type or is this individual currently the subject of a pending disciplinary action or unresolved complaint? ☐ YES ☐ NO. If yes, please forward all publicly disclosable information regarding the individual's status and the basis for same. Please advise this office if you require consent for release of this information from the applicant.

Name: _____ Signature**:** _____

Title**:** _____ Name of Agency: _____
Address: _____ City/State/Zip: _____
Telephone Number: _____ email: _____

Please return this form via email to dph.emslicensing@ct.gov, via fax to (860) 920-3142 or by mail to:

Click to print form

Connecticut Department of Public Health, EMS Certification
410 Capitol Ave., MS#12EMS,
P.O. Box 340308
Hartford, Connecticut 06134-0308
860.509.7975

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REV 1 | 2024