



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH



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.

Empty rectangular box for providing a brief description of requirements if 'NO' is selected.

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:

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