Rhode Island Department of Health
Center for Emergency Medical Services

3 Capitol Hill , Room 105
Providence, RI 02908-5097

Application For

License as an Emergency Medical Services Practitioner

Select the level of EMS license you are applying for (check one):

☐ **EMR** ☐ **EMT** ☐ **AEMT** ☐ **Advanced EMT-Cardiac (AEMT-C)** ☐ **Paramedic**

MILITARY STATUS ELIGIBILITY *(Documentation Required) see last page for instructions*

Please check ONE of the following criteria for expedited application:

☐ I am in active military duty or a reservist
☐ I am a military veteran with honorable discharge
☐ I am the spouse of someone in active military duty or the spouse of a reservist

Applicant - Print Name

LAST NAME	***FIRST NAME***	***MI***

Do Not Hand Deliver - Application Must Be Mailed

FOR DEPARTMENT OF HEALTH USE ONLY

☐ Approved ☐ Denied Date_____ By_____

EMT#_____ Expiration Date:_____

Phone: (401) 222-2401 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-3352**

Revised 02/08/2019 jcp

GENERAL INFORMATION

1. Requirements for EMS practitioner licensure are established by the Rules and Regulations 216-RICR-20-10.2 available through the Center for EMS website at http://www.health.ri.gov/licenses

2. EMT licensure can be denied pursuant to the provisions of the Rules and Regulations 216-RICR-20-10.2. Statements or documents may be considered sufficient cause to deny or revoke a license as an EMS practitioner in Rhode Island and may result in additional penalties as determined by law. The Department may conduct random application audits, requiring the EMS practitioner applicant to file proof of completion of the above training requirements for renewal.

3. Should you have any questions regarding the EMS practitioner license requirements or completion of the application form, contact (401) 222-2401.

4. Please allow 4-6 weeks for applications to be processed. You can visit our website at http://www.health.ri.gov and click on Verify a License in order to check on the status of your application.

→ **PLEASE NOTE: This application form (dated 02/08/2019) supplants all previous versions. Prior versions of the application will not be accepted or processed.**

APPLICATION INSTRUCTIONS

1. Complete all application materials as instructed. Please answer all questions. Incomplete questions or incomplete applications will not be processed. Please mark "NA" on questions that are Not Applicable.

2. Do not detach any full pages from this booklet.

3. Please type this application using the filliable form online then print the completed application.

4. Sign the application and return it with the required fee(s).

   Do not submit the application without all applicable information, documentation and fee(s).

5. Mail the completed application to: (Do Not Hand Deliver)
   Rhode Island Department of Health
   Division of Emergency Medical Services
   Room 104, 3 Capitol Hill
   Providence RI 02908-5097

   Please note: Extra postage will be required.

6. **Faxed applications WILL NOT be accepted.**

PERSONAL CHECKS WILL NOT BE ACCEPTED. PAYMENT MUST BE A (CASHIER'S CHECK OR MONEY ORDER)

REQUIRED DOCUMENTATION

- ☐ 1. **ALL** applicants at any level must submit an **ORIGINAL** Bureau of Criminal Identification (BCI) report supported by fingerprints. You must apply to the Department of Attorney General's Office. For information on this process please visit: http://www.riag.state.ri.us/homeboxes/BackgroundChecks.php. Out-of-state applicants should check with the Attorney General's office from their state of residence.
- ☐ 2. Photostatic copy (front and back) of a **current - signed** Healthcare Provider level or equivalent cardiopulmonary resuscitation (CPR) card eg. (American Heart Association Healthcare Provider, American Red Cross Professional Rescuer, American Safety and Health Institute CPRPRO, Medic First Aid BLSPRO, or National Safety Council Professional Rescuer CPR). **This card must be signed.**
- ☐ 3. **For First-Time Applicants -** photostatic copy of High School Diploma or GED
- ☐ 4. Photostatic copy of diploma or certificate from the licensed EMS training provider verifying completion of the EMT training program specific to the level of licensure application.
- ☐ 5. **EMR, EMT, AEMT and Paramedic Applicants -** photostatic copy of current NREMT Registration

  In Addition to 1-6 Out of State AEMT Applicants Must Also Complete 6-8

- ☐ 6. Photostatic copy of EMS Practitioner license from a state other than Rhode Island, if applicable.
- ☐ 7. Photostatic copy of current registration with the National Registry of Emergency Medical Technicians if applying for EMR, EMT, AEMT or Paramedic.
- ☐ 8. Interstate Verification Form completed by each state (other than Rhode Island) in which the applicant has been licensed.

IMPORTANT: Licensure is an individual responsibility and NOT the responsibilty of your employer or supervisor.

State of Rhode Island
Center for Emergency Medical Services
Application for License as an Emergency Medical Technician

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your license and reported to those who inquire about your license. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Divison of Taxation to verify that no taxes are owed to the State.

3. Gender

☐ Male ☐ Female

4. Date of Birth

Month Day Year

5. Home Address

It is your responsibility to notify the EMS Office of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S.

Postal Code, If NOT U.S.

Home Phone

Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Rhode Island License

Please provide information concerning your previous licensure in the State of Rhode Island, if applicable.

Have you **ever** been licensed as an EMT in Rhode Island? ☐ Yes ☐ No

If the answer to this question is ***"yes"***, provide license number, and if applicable, enter all other state abbreviation(s) of EMT licenses you hold or may have held in Question 7.

Rhode Island License Number EMT

License Number

7. Other State Licensure

List all states or countries in which you are now or ever have been licensed to practice as an EMT.

YOU must send a copy of the Interstate Verification Form to each entity (see page 10).

State/Country:			State/Country:		
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive
	☐ Active	☐ Inactive		☐ Active	☐ Inactive

8. Program Information

Name of Program Director

Name of Medical Director

IC

License Number of Instructor-Coordinator

EMS Training Institution

Month	Day	Year	Month	Day	Year

9. Disaster Availability

I am interested in becoming a volunteer emergency responder during a disaster or state of emergency. ☐ Yes ☐ No

10. Rhode Island Ambulance Service Affiliation

Please list only ONE affiliation. If you have no affiliation, please mark question as NA.

Licensed Ambulance Service

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City | State | Zip Code

Country, If NOT U.S. | Postal Code, If NOT U.S.

Business Phone | Extension | Business Fax

11. Licensed Ambulance Service Verification

To be completed by Chief of department or service.

I hereby certify that _____ is a bonafide member of my EMS Service/Department and that said affiliation is true and accurate.

Printed Name of Chief

Signature of Chief

Date of Signature

12. Active Military or Veteran

Are you or your spouse a veteran or active military?

- ☐ Yes, I am a veteran or active military
- ☐ Yes, my spouse is a veteran or active military
- ☐ No, neither I nor my spouse would be considered veterans or active military

If applying for expedited military status you must include one of the following: Leave Earning Statement (LES), Letter from Command, Copy of Orders or DD-214 showing honorable discharge.

13. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, pleaded *Nolo Contendere*, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance, or are any formal charges pending? ☐ Yes ☐ No

Abbreviation of State and Conviction[1] (e.g. CA - Illegal Possession of a Controlled Substance):

	Month	Year

14. Disciplinary Questions

Check either Yes or No for each question.

1. Has any health professional license, certificate, registration, or permit you hold or have held, been disciplined or are formal charges pending? ☐ Yes ☐ No
2. Have you ever been denied a health professional license, certificate registration or permit in any state? ☐ Yes ☐ No
3. Has an Ambulance Service, for any reason, ever suspended, restricted, or placed on probation your EMS privilege to practice? ☐ Yes ☐ No

Note: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper.

15. National Registration

Please provide certification information below:

NREMT#: Expiration Date Month Day Year

Exam Date: Month Day Year

16. Payment of Fees

Select appropriate fees and enclose payment as instructed.

PERSONAL CHECKS ARE NOT ACCEPTED

CASHIER'S CHECK OR MONEY ORDERS ONLY.

☐ EMT and AEMT-C Application Fee **$120.00**

☐ EMR, AEMT, and Paramedic Application Fee **$80.00**

TOTAL ENCLOSED $ **00**

☐ I am exempt from application fees (see below, must complete Items #10 and #11)

EXEMPTIONS: Per Rhode Island General Law 23-4.1-10 the following categories of Rhode Island Licensed EMS Providers are considered "exempt":

- Licensed city or town services, vehicles and their employees.
- Licensed volunteer or not-for-profit services, vehicles and individuals providing services therein.
- Licensed fire district service, vehicles and individuals providing services therein.

Required fees must accompany the application.

PERSONAL CHECKS ARE NOT ACCEPTED

Fees must be made payable to the General Treasurer, State of Rhode Island and must be either a Cashier's Check or Money Order.

PLEASE NOTE: **ALL FEES ARE NON-REFUNDABLE**

17. Affidavit of Applicant

Complete this section and sign.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a Emergency Medical Technician in the State of Rhode Island.

I understand that my records are protected under the Federal and State Regulations governing Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the law. I understand that my records are protected under the Federal and State Laws and Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Center for Emergency Medical Services of any change in the answers to these questions after this application and this affidavit is signed.

Signature of Applicant

Date of Signature (MM/DD/YY)

Substitute forms are not acceptable - Copy this form as needed.

Center for Emergency Medical Services
Room 104, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-2401

INTERSTATE VERIFICATION FORM - ORIGINAL AND ALL OTHER STATES OF LICENSURE

Applicant Instructions: Complete the top portion of this form and forward it to each state or territory where you have been trained and/or licensed, certified or registered as an Emergency Medical Services provider (make copies as necessary).

I am applying for a license to practice as an Emergency Medical Services Pracitioner in the State of Rhode Island. The Rhode Island Center for Emergency Medical Services requires that the following form be completed by the jurisdiction in which I obtained my original training and/or license and all other states of licensure. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Division of Emergency Medical Services at the above address.

Print/Type Full Name _____ Signature _____ Date _____

Previous Names Used _____ Social Security Number _____ Date of Birth _____

Address _____ City _____ State _____ Zipcode _____

Contact Phone Number and Email address _____ License Number _____ Date Issued _____

THIS SECTION TO BE COMPLETED BY THE EMS LICENSING AGENCY

EMT Program Completed:	**Location:**	**Graduation Date:**
License Status: ☐ Active ☐ Inactive ☐ Lapsed	**Original Date Issued:**	**Expiration Date:**

Questions:

1. Has this licensee ever been investigated by your office? ☐ Yes ☐ No
2. Has this licensee incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No
4. Do you know of any information that may discredit this person? ☐ Yes ☐ No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Agency order, complaint, etc.).

Location of Course (Include printout of initial EMT course):_____ Date that Certificate was issued: _____

Certification:

Signature _____ Date _____

Type or Print Name _____ Title _____

Please Affix Board Seal Here

Full Name of Licensing Agency _____

Please return directly to EMS at the above address.