pennsylvania
DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

Emergency Medical Services Provider Certification Application

(Please print legibly)

SECTION A – PERSONAL INFORMATION

Last Name (include Maiden Name, if applicable)	First Name	Middle Name	Suffix (Jr, Sr, II, III)

Mailing Address	City	State	Zip Code

Home Telephone Number	Work Telephone Number	Email Address
( )	( )	

Date of Birth: **Gender:** **County:**

Purpose for completing this form □ Initial Certification □ Reciprocity □ Lapsed Registration

Have you held or are you currently holding and/or requesting any of the following certification levels?

□ Held	□ Current	Emergency Medical Services Vehicle Operator (EMSVO)	□ Requesting
□ Held	□ Current	EMS Instructor	□ Requesting
□ Held	□ Current	First Responder/Ambulance Attendant (FR/AA)	□ Requesting
□ Held	□ Current	Emergency Medical Responder (EMR)	□ Requesting
□ Held	□ Current	Emergency Medical Technician (EMT)	□ Requesting
□ Held	□ Current	Advanced Emergency Medical Technician (AEMT)	□ Requesting
□ Held	□ Current	Paramedic (P)	□ Requesting
□ Held	□ Current	Pre-Hospital Registered Nurse (PHRN)	□ Requesting
□ Held	□ Current	Pre-Hospital Physician Extender (PHPE)	□ Requesting
□ Held	□ Current	Pre-Hospital EMS Physician (PHP)	□ Requesting
□ Held	□ Current	Medical Command Physician (MC Physician)	□ Requesting
□ Held	□ Current	Other _____	□ Requesting

Most Recent EMS Educational Institute Previously Attended:

Mailing Address	City	State	Zip Code

Telephone Number	Dates Attended
( )	County

EMS Educational Institute Enrolling in or Currently Attending:

Mailing Address	City	State	Zip Code

Telephone Number	County
( )	Class Number

EMS Certifications Previously Held Or Currently Held In PA, Other States or US Territories:

Provider Level: _____ **Cert Number:** _____ **State:** _____ **Exp Date:** _____
Provider Level: _____ **Cert Number:** _____ **State:** _____ **Exp Date:** _____
Provider Level: _____ **Cert Number:** _____ **State:** _____ **Exp Date:** _____
NREMT Level: _____ **Cert Number:** _____ **Exp Date:** _____

Copy of current certification card(s) shall be attached.

Name_____
Last First MI

National Registry Certification Obtained Thru United States Military:			
☐ Air Force ☐ Army ☐ Coast Guard ☐ Marines ☐ Navy			
Most recent US Military Mailing Address	**City**	**State**	**Zip Code**
Telephone Number			
( )	**National Registry Certification #**		

Have you ever been convicted of a crime other than a summary or similar offense?

☐ Yes – Complete all sections
☐ No – Skip Section B

A conviction includes a judgment of guilt, a plea of guilty, or a plea of nolo contendere. Accelerative Rehabilitative Disposition (ARD) is not considered a conviction. Include all offenses committed as a juvenile in which you were adjudicated delinquent. Include all offenses

SECTION B - CRIMINAL CONVICTIONS

Common Name of Offense & Grading (felony or misdemeanor, if known)	Date of Conviction	State of Conviction	County of Conviction

If you responded with a positive criminal history, the Bureau requires that you provide this office with certified copies of all of the following court documents with the County or the Clerk of Court's office seal or stamp on each document to verify that the documents are exact copies of the original documents:

- ☐ **The Police Criminal Complaint, including the Affidavit of Probable Cause**
- ☐ **The Criminal Information or Indictment**
- ☐ **Guilty Plea Document or Jury/Court Document imposing a finding of guilty**
- ☐ **The Court's Sentencing Order**

For juvenile cases, you may be required to submit copies of the above documents. You are encouraged to provide letters from probation/parole officers, past/present employer(s), clergy, doctors, warden, law enforcement officials, public officials, etc., evidence of rehabilitation, and/or records of good conduct or community service.

If you were convicted in a Federal court or another court not part of Pennsylvania's judicial system, provide documents equivalent to those referenced in section B, as well as a copy of the statute under which you were convicted.

Background checks may be performed to verify the information you provide on this form. If you have made a false statement or failed to identify all relevant conditions, your application may be denied or disciplinary action may be initiated against you by the Department or a criminal justice agency and that action may impact upon any certification or recognition you have received or may receive from the Department.

Describe the circumstances surrounding the crime(s) for which you were convicted:

Name_____
Last First MI

Explain how the passage of time since your conviction(s) should be considered in determining your present fitness to serve as an EMS provider:
What are you doing to avoid criminal activity and to improve yourself?
Do you believe you will not be involved with future criminal activity? Why?
Are you on probation/parole? □ Yes Date of completion: _____ □ No
Name of Probation/Parole Officer: Telephone Number:
City/County/State of probation/parole?
Date of or projected date of completion of probation/parole?
Were you previously on probation/parole? □ Yes □ No
Name of former Probation/Parole Officer: Telephone Number:
Was court ordered counseling classes/evaluation part of your probation/parole? □ Yes □ No (If yes, complete below)
Type of court ordered sessions:
Are you going to counseling voluntarily? □ Yes □ No (If yes, complete below)
Type of voluntary sessions:
Name of Counselor: Telephone Number:
Date or projected date of successful completion of counseling/classes:

Section C - Emergency Medical Services Vehicle Operator (EMSVO) Applicant Only

Within the past 4 years, has your driver's license been suspended or revoked? □ Yes □ No
If yes, attach your official state driving history record. If Pennsylvania resident, a driving history record can be obtained on-line at:
https://www.dot3.state.pa.us/driver_services/dllogin.jsp#top?20140106080749380=20140106080749380

Failure to supply the Bureau with complete and factual criminal history documentation and/or driving history record will result in a delay in evaluating and processing your documentation and therefore will delay your eligibility to participate in EMS certification examinations.

Failure to supply the Bureau with complete and factual criminal history documentation and/or driving history record may result in the Department taking action to suspend or revoke your certification as an EMS Provider.

Reciprocity Candidates:
All applicants for EMS certification reciprocity are required to submit proof of affiliation with a PA licensed EMS agency, criminal history documentation and a driving history record from current state of certification. Incomplete applications will not be evaluated or processed. Applications without proof of affiliation will have 120 days from the application date to provide documented proof of affiliation with a PA licensed EMS agency.

SECTION D – DISCIPLINARY ACTION DISCLOSURE

Have you been subject to disciplinary action or had a certification or license or authority to practice any profession or occupation revoked, suspended or restricted? □ Yes □ No (If yes, provide circumstances of the disciplinary action):

Name_____
Last First MI

SECTION E – SOCIAL SECURITY NUMBER DISCLOSURE

Pursuant to section 4304.1(a)(2) of the Domestic Relations Code, 23 Pa.C.S. § 4304.1(a)(2), government agencies are required to collect the Social Security Number of an individual who has one on any application for a professional or occupational license or certification. Any information collected pursuant to this section shall be confidential except as permitted by law. The information collected may be used in obtaining a criminal history record check of you and it may be provided to, and used by, the Department of Public Welfare, upon its request, or a court or domestic relations section solely for the purpose of child and spousal support enforcement and, to the extent allowed by Federal law, for administration of public assistance programs.

Section 2603 of the State Government Code, 71 P.S. § 2603, allows an individual applying for or renewing a professional or occupational license or certification to provide an alternate form of identification in lieu of a Social Security Number. Alternate forms of identification acceptable to the Bureau are an individual's Pennsylvania Driver's License Number or a Pennsylvania Non-Driver's Identification Card Number issued by the Pennsylvania Department of Transportation (PennDOT). Out-of-state driver's license numbers or identification cards are not acceptable.

Please note that if you provide a PennDOT identification number in lieu of your Social Security Number, the Department of Health is still required to obtain your Social Security Number pursuant to 23 Pa.C.S. § 4304.1(a)(2). The Department of Health will contact PennDOT and provide your PennDOT identification number in order to obtain your Social Security Number. The Bureau of EMS will not process your paperwork for certification until it receives your Social Security Number from PennDOT. Be aware that this will delay the issuance of any EMS certification to you for which you qualify.

If you do not have a Social Security Number, you must complete the attached "Waiver of SSN Verification Statement" before your paperwork will be forwarded to the Bureau of EMS for processing. Prior to the expiration of your initial certification period, you will be required to obtain and provide to the Bureau of EMS a Social Security Number or you will be required to obtain from the Social Security Administration (SSA) documentation showing that you have applied for a Social Security Number or a certification from the SSA that you are not eligible for one. If you are not eligible for a Social Security Number, you may be required to obtain an Individual Taxpayer Identification Number (ITIN) from the Internal Revenue Service before you will be granted EMS certification.

Name (as it appears on card)	Social Security Number

In lieu of a Social Security Number, I am providing: □ PA Driver's License □ PA Non-Driver's Identification Card

Name (as it appears on card)	Address (as it appears on card)	Number

By affixing my driver's license number or non-driver's identification number issued by the Pennsylvania Department of Transportation, I authorize the Pennsylvania Department of Transportation to release my Social Security Number to the Pennsylvania Department of Health for the limited purpose of complying with 23 Pa.C.S. § 4304.1(a)(2).

NOTICE: Section 4904 of the PA Crimes Code provides that:

(a) A person commits a misdemeanor of the second degree if, with intent to mislead a public servant in performing his official function, he:

(1) Makes any written false statement which he does not believe to be true; or
(2) Submits or invites reliance on any writing which he knows to be forged, or otherwise lacking in authenticity.

(b) A person commits a misdemeanor of the third degree if he makes a written false statement which he does not believe to be true, on or pursuant to a form bearing notice, authorized by law, to the effect that false statements made thereon are punishable.

Name_____
Last First MI

SECTION F – WAIVER AND SIGNATURE

I hereby certify that the information provided in this form is **true and complete** to the best of my knowledge, information and belief. I further acknowledge that I am on notice of the fact that this information will be relied upon by a public official to perform official functions. I further acknowledge that I have read the above Notice and am aware that false statements that are made herein are punishable under the Pennsylvania Crimes Code. I authorize and hold harmless the Pennsylvania Department of Health to contact the law enforcement, correctional officers, present and past employers, counseling programs, and anyone specifically noted on this application and any other persons that might have information pertaining to my conviction(s). I further authorize these entities to release information as allowed by law related to my convictions. I agree to sign any waivers or authorizations from these entities to release information related to my convictions if they require I do so. I understand that if I am denied certification or have disciplinary sanctions imposed against me by the Department it may publish information of its action and reasons for its decision on its web page and to the federal government. I further understand that completion of an EMS course does not guarantee issuance of certification.

Printed Name _____ Signature _____ Date _____

WAIVER OF SOCIAL SECURITY NUMBER VERIFICATION STATEMENT

Certification Level:

- ☐ Emergency Medical Services Vehicle Operator (EMSVO)
- ☐ EMS Instructor
- ☐ First Responder/Ambulance Attendant (FR/AA)
- ☐ Emergency Medical Responder (EMR)
- ☐ Emergency Medical Technician (EMT)
- ☐ Advanced Emergency Medical Technician (AEMT)
- ☐ Paramedic (P)
- ☐ Pre-Hospital Registered Nurse (PHRN)
- ☐ Pre-Hospital Physician Extender (PHPE)
- ☐ Pre-Hospital EMS Physician (PHP)
- ☐ Medical Command Physician (MC Physician)
- ☐ Other _____

This is to verify that I do not have a social security number for the following reason(s):

_____

_____

_____

I verify that the statement made above is true and correct to the best of my knowledge, information, and belief. I understand that false statements are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and may result in disciplinary action and/or criminal charges.

I also acknowledge that I will provide the Bureau with my Social Security Number or other acceptable form of identification (see application form, Section E) as soon as it is obtained. Further, I understand that I will not be permitted to renew my certification, including upgraded certifications, until I have submitted acceptable verification to the Bureau. I further understand that I must submit this information before the expiration of the time period of my initial certification, regardless of whether I upgraded my initial certification.

Signature _____ Date _____

Name_____
Last First MI

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Bureau of Emergency Medical Services

STUDENT RELEASE AND CONSENT FORM

RELEASE STATEMENT:

In compliance with the federal Family Educational and Rights to Privacy Act of 1974 and the Buckley Amendment, I authorize and give my permission to the Pennsylvania Department of Health and the Pennsylvania Regional EMS Council to release information concerning my training records to: (1) the primary instructor of this course: (2) the local EMS Educational Institute, if this course is being conducted within, or in collaboration with, such institute; (3) any federal or state agency (or other) authority to certify, regulate, and/or fund EMS programs and personnel; and/or (4) _____.

Applicant Signature_____ Date_____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date_____

PARENTAL PERMISSION FOR CERTIFICATION EXAMINATION PARTICIPATION

(TO BE COMPLETED BY A PARENT/GUARDIAN OF APPLICANTS WHO ARE AT LEAST 16, BUT NOT YET 18 YEARS OF AGE)

I hereby give permission for _____ (Legal Name of Applicant) to participate in state recognized certification examinations conducted by a PA Accredited EMS Educational Institute. I also give permission for the Department of Health, Bureau of Emergency Medical Services, or its authorized agents, to obtain or request from the applicant or third parties any records, documentation or other information about the applicant as required under state and federal laws for the purpose of state certification. I also certify that the applicant, of whom I am the parent or guardian, signed this application where required and I consent to the conditions and waivers contained in this document.

I understand the Pennsylvania Department of Health is not authorized to provide travel, medical, or health insurance to students. I also understand my child may be exposed to infectious diseases and physically strenuous and/or hazardous environments.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date_____

Name_____
Last First MI

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EMS AFFILIATION VERIFICATION
(For PA Reciprocity ONLY)

Applicant Legal Name: _____Last four digits of SSN_____

1. PA LICENSED EMS AGENCY VERIFICATION (To be completed by the principal official of requesting EMS Agency)

Agency letterhead indicating candidate approval for employment or volunteer affiliation shall be attached.

Current Pennsylvania EMS Agency Affiliation Identification number ☐☐☐☐☐☐

Name: _____**County**_____

I verify that the candidate named on this form has been offered employment or a volunteer position pending issuance of a Pennsylvania EMS Provider Certification and will be providing care with this EMS Agency.

Signature: _____ Title: _____ Date: _____

Printed Name: _____ Day Telephone: (____) _____
Email Address: _____

2. PENNSYLVANIA ACCREDITED EMS EDUCATIONAL INSTITUTE VERIFICATION (This section **SHALL** be completed by the approved verifying institute representative for all candidates not desiring affiliation with a Pennsylvania Licensed EMS Agency)

☐ ACCREDITED ALS EDUCATIONAL INSTITUTE ☐ ACCREDITED BLS EDUCATIONAL INSTITUTE

National Accreditation #_____ State Accreditation #_____

I verify that the candidate named on this form is affiliated with a recognized and accredited Pennsylvania EMS Educational Institute.

Signature: _____ Title: _____ Date: _____

Printed Name: _____ Day Telephone (____) _____
Email address: _____

3. MEDICAL DIRECTOR VERIFICATION (This section shall be completed by the approved verifying agency representative for all candidates)

I verify that the candidate named on this form has met all local and state eligibility requirements in order to pursue Pennsylvania EMS Provider Certification with the intent to function in the EMS Agency Program of which I am the Medical Director.

Medical Director
Signature: _____ Date: _____

Printed Name: _____ Day Telephone (___) _____
Email Address: _____

4. APPLICANT SIGNATURE I understand that ALL information on this form is correct to the best of my Knowledge, and is subject to verification. Failure to meet any requirements may serve as grounds of ineligibility for certification.

Applicant's signature: _____ Date_____