

County of San Luis Obispo Public Health Department
 Division: Emergency Medical Services Agency

Policy 320 & 321 Attachment A
 Effective Date: 03/01/2023

EMT APPLICATION FOR CERTIFICATION

Check one: **Initial Certification** **Re-certification**

APPLICANT INFORMATION					
Last Name:			First Name and Middle Initial:		
Mailing Address, PO Box/Street:			Residence Address (if different than mailing):		
City:	State:	Zip:	City:	State:	Zip:
<input type="checkbox"/> This is a change of address			<input type="checkbox"/> This is a change of address		
Cell Phone Number:			Personal Email:		
Home Phone Number:			Work Email:		
Date of Birth:	Age:	CA Driver's License #:	Last 4 Digits of SSN:		
Current CA State EMT #:		Effective Date:		Expiration Date:	
EMS Provider Employer Information			**FOR INITIAL APPLICATION ONLY**		
Name:		California Assembly Bill 2293 requires local EMS Agencies to collect and report to the EMS Authority, on an annual basis, certain demographic data points.			
Phone Number:		RACE/ETHNICITY – PLEASE CHECK ONE			
Address:			<input type="checkbox"/> American Indian or Alaska Native		
City:	State:	Zip:	<input type="checkbox"/> Asian		
<input type="checkbox"/> This is a change of employment.			<input type="checkbox"/> Black or African American		
EMS AGENCY USE ONLY			<input type="checkbox"/> Hispanic or Latino		
<input type="checkbox"/> Central Registry Checked			<input type="checkbox"/> Native Hawaiian or Other Pacific Islander		
<input type="checkbox"/> Background Checked, Date:			<input type="checkbox"/> White		
<input type="checkbox"/> Megan's Law Checked			<input type="checkbox"/> Decline to state.		
<input type="checkbox"/> Access Database Updated			GENDER – PLEASE CHECK ONE		
<input type="checkbox"/> MLO Certification Updated			<input type="checkbox"/> Female		
Date Card Sent to Applicant:			<input type="checkbox"/> Male		
Card Effective Date:			<input type="checkbox"/> Other (non binary)		
Card Expiration Date:			<input type="checkbox"/> Decline to state.		
Verified by and Date:					

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USE APPROPRIATE CHECK LIST BELOW AND SIGN. SUBMIT BOTH PAGES.

Applicant Name:

Date:

EMT CERTIFICATION		EMT RE-CERTIFICATION	
<input type="checkbox"/> Completed Application (both pages).		<input type="checkbox"/> Completed Application (both pages).	
<input type="checkbox"/> National Registry course certificate or Current NREMT Card.		<input type="checkbox"/> Copy of Current Certification Card.	
NREMT Number:		<input type="checkbox"/> Skills Verification Form.	
Expiration Date:		Continued Education:	
<input type="checkbox"/> EMT Basic Course Completion Certificate.		<input type="checkbox"/> 24 Hours of CA Approved EMS CEs.	
Training Program:		<input type="checkbox"/> 24 Hours from Approved EMT Refresher Course.	
Date of Completion:		<input type="checkbox"/> 36 Hours of CE (expired for 6 to 12 months).	
<input type="checkbox"/> Out of State current EMT Certificate (if applicable).		<input type="checkbox"/> 48 Hours of CE (expired for over 12 months).	
Certificate Number:		<input type="checkbox"/> DOJ / FBI Live Scan Receipt if previously certified elsewhere.	
Expiration Date:		<input type="checkbox"/> On file.	
<input type="checkbox"/> DOJ / FBI Live Scan Receipt.		<input type="checkbox"/> Grandfathered Employer Letter*	
<input type="checkbox"/> Copy of CA Paramedic License (if applicable).		<input type="checkbox"/> Copy of CA Paramedic License (if applicable).	
<input type="checkbox"/> Copy of CA Driver's License or government issued photo ID.		<input type="checkbox"/> Copy of CA Driver's License or government issued photo ID.	
<input type="checkbox"/> Copy of CPR Card.		<input type="checkbox"/> Copy of CPR Card.	
Expiration:		Expiration:	
<input type="checkbox"/> AHA-BLS Healthcare Provider		<input type="checkbox"/> AHA-BLS Healthcare Provider	
<input type="checkbox"/> ARC-BLS Healthcare Provider		<input type="checkbox"/> ARC-BLS Healthcare Provider	
<input type="checkbox"/> Other (CAPCE approved BLS Healthcare Provider).		<input type="checkbox"/> Other (CAPCE approved BLS Healthcare Provider).	
<input type="checkbox"/> Non-refundable application fee.		<input type="checkbox"/> Non-refundable application fee.	

DECLARATION and ATTESTATION

Have you ever been convicted of any felony or misdemeanor offense, in California or in any other state or place, including entering a plea of nolo contendere or no contest and including any conviction, which has been expunged (set aside)?

On File with SLO EMSA Yes No

Have you ever had a certification, accreditation, or professional healing arts license denied, suspended, revoked or placed on probation, or are you under investigation at this time?

On File with SLO EMSA Yes No

Are there any criminal charges currently pending against you?

Yes No

If you answered yes to any of the above questions, you must submit with this application a written explanation that describes the crime(s), date, location, court, sentence served, and parole if any, and/or the action taken against your certification, accreditation or professional license, any corrective action, and/or remediation as a result of the action. You must also attach any applicable court documents and police reports.

Attestation: I hereby certify under penalty of perjury that all information on this application is true and correct to the best of my knowledge and belief, and I understand that any falsification or omission of material facts may cause forfeiture on my part of all rights to EMT certification in the state of California. I understand all information on this application is subject to verification, and I hereby give my express permission for this certifying entity to contact any person or agency for information related to my role and function as an EMT in California. Additionally, by signing this application I do authorize the release of all prior EMT application and/or certification action documentation for use of verification by County of SLO EMS Agency. It is my responsibility to notify the EMS Agency within 7 days of any arrest or change in my eligibility status. I also understand the application fees are non – refundable and that California Regulations require me to notify the EMS Agency in writing within 30 days of any change in my mailing address.

Signature of Applicant:

Date: