2016 EMS REGISTRATION

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SYSTEMS
SFN 52195 (01/2016)

*This form **must** be completed in its entirety or it will be returned.* This form must be completed by:

1. Students in EMT, AEMT, and Paramedic courses and submitted by the course coordinator to DEMS upon **starting** the course.
2. Students in EMR, EMD, EVOC, or Auto Extrication courses and submitted to DEMS by the course coordinator with the course roster upon **course completion**.
3. Basic level EMS personnel as application for state licensure and/or re-licensure.
4. Any personnel requesting to be added to an EMS agency roster (requires signature by agency squad leader/manager) or requesting name / address changes.

Note: Squad leaders have on-line access to their rosters and may make personnel changes through the website.

Submit to: North Dakota Department of Health; Division of EMS; 1720 Burlington Dr; Bismarck ND 58504
Fax: 701.328.0357 E-mail: dems@nd.gov

REASON FOR APPLICATION SUBMISSION:

☐ EMR License	☐ AEMT Student	ALS Providers must complete an ALS license application signed by their medical director to apply for licensure.	☐ Auto Extrication ☐ Driver
☐ AFAA License	☐ Paramedic Student		☐ Dispatch ☐ Driver w / CPR (Must include copy of CPR card)
☐ State EMT License (Under 18 State License)			☐ EVOC ☐ Registered Nurse (Include copy of state license)
☐ EMT Student	☐ EMT License		☐ CEC / IC ☐ Other (please specify)

ND State EMS Number	Social Security Number	National Registry Number

First Name	Last Name	MI

Home Street Address / PO Box	City	State	Zip Code

County	E-Mail Address	☐ Male ☐ Female

Date of Birth	EMS Agency Affiliation	☐ Additional Affiliation ☐ Replacement Affiliation

Home Telephone Number	Work Telephone Number	Cell Phone Number

Course Authorization Number (Obtain from instructor) *(Initial class registration only)	Course Completion Date

Do you receive monetary compensation as an EMS Provider?	☐ Yes	☐ No	If so do you receive more than $10,000.00 per year?	☐ Yes	☐ No

PRIVACY ACT STATEMENT

Your social security number is being requested to permit the North Dakota Department of Health to verify your eligibility to become nationally registered and to properly conduct a criminal history background investigation pursuant to N.D.A.C section 33-36-01-05 before issuing licensure or certification. Disclosure of your social security number is voluntary. If you are not willing to disclose your social security number, you must supply an official current criminal history background check in order to obtain licensure or certification as required to work as an EMS provider in North Dakota.

CRIMINAL CONVICTION STATEMENT - FORM WILL BE RETURNED IF THIS SECTION IS NOT COMPLETED.

☐ **Yes** ☐ **No** **1. Have you ever been convicted of any violation of any federal, military, state or local laws (excluding non-criminal traffic violations?**

☐ **Yes** ☐ **No** **2. Have you ever had any license, certification, or right to practice denied or surrendered, or disciplined with suspension, reprimand, probation, revocation, or any other method of discipline in North Dakota or any other state or jurisdiction?**

☐ **Yes** ☐ **No** **3. Are you the subject of any pending investigation, administrative sanction proceeding, hearing, trial or similar action by an agency or board that has granted or denied you a license, certification, or right to practice in any regulated occupation, trade or profession in North Dakota or in any other state or jurisdiction?**

☐ **Yes** ☐ **No** **4. If yes to either 1, 2, or 3 have you previously submitted this information / documentation to DEMS?**

**If any of 1 - 3 above have been marked yes, you must provide official documentation that fully describes the offense, current status,and disposition of the case if you have not submitted documentation to DEMS in the past.*

I hereby affirm and declare that the above information is true and correct and that fraudulent entries may be sufficient cause for rejection or revocation. I understand that fraudulent entries may be considered a crime and may be prosecuted under state law. I further agree to notify the ND Department of Health Division of Emergency Medical Systems immediately if any changes in my status should occur and give permission to the Division of Emergency Medical Systems to perform a criminal background check.

Signature	Date

Signature of squad leader / manager required ONLY when adding personnel to EMS agency roster.

Signature of listed agency's squad leader / manager on record	Date