NORTH Dakota | Health
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2020 ALS PROVIDER LICENSE / (COVID-19) APPLICATION

Division of Emergency Medical Systems
1720 Burlington Dr • Bismarck ND 58504-7736
701-328-2388 • 701-328-0357 (f) • dems@nd.gov • health.nd.gov
SFN 17393 (03/2020)

*This form **must** be completed in its entirety or it will be returned.* This form is required for all advanced level EMS personnel as application for state licensure and/ or re-licensure. **An application must be submitted for each agency affiliation.** An EMS registration form is not required for ALS personnel.
Submit completed form to the Division of Emergency Medical Systems.

Licensure Level	***Please select if appropriate:*** ☐ **Community Paramedic** ☐ **Critical Care Paramedic**	
Select 'Provisional' or 'Temporary' along with licensure level as appropriate. ☐ **AEMT** ☐ Provisional ☐ **Paramedic** ☐ Temporary	ND State EMS Number	Social Security Number
	National Registry Number	Date of Birth

First Name	Last Name	MI

Home Street Address / PO Box	City	State	Zip Code	County

E-Mail Address	☐ Male ☐ Female	Home Telephone Number	Work Telephone Number

Cell Phone Number	EMS Agency Affiliation	◯ Additional Affiliation	◯ Replacement Affiliation

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 requested to permit the North Dakota Department of Health to verify eligibility to become nationally registered and to properly conduct a 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, however, not providing this information may result in a processing delay due to misidentification criminal records check requirements of state, local or federal agencies, or identification requirements of the National Registry of Emergency Medical Technicians.

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 also 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 Services and Trauma immediately if any changes in my status should occur. I also give permission to the Division of Emergency Medical Systems to perform a criminal background check.

Signature	Date

MEDICAL DIRECTOR AGREEMENT

The above named person is employed by an ambulance service, rescue squad, or health care setting for which I am the Medical Director. Upon state licensure as an Advanced Level EMS Professional by the North Dakota Department of Health of the person named above, I will provide medical direction consisting of verbal, written, or standing orders allowing the above named person to provide medical care consistent with the skills defined by the North Dakota Scope of Practice.
I will assure that the person named above continues to remain competent in the skills contained in the North Dakota scope of practice. I have complete discretion as to which skills or treatment modalities listed in the North Dakota Scope of Practice for EMS providers the above named person may provide during the normal course of his/her duties.
I understand that the above named person is allowed to provide patient care to the level of licensure as a part of my practice and only as a result of my delegation of the authority to do so. I further understand that I may revoke this authority at any time. If I revoke this authority, I will provide the Division of Emergency Medical Systems with written notification of the revocation.

This agreement expires upon termination from the above named agency or 90 days after National Registry Expiration.

Medical Director Signature	License Number	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