

## **General Instructions Checklist EMS Supervisor/Medical Program Director Signature Form**

The EMS Supervisor/Medical Program Director Signature form is required for each of the following applications:

- Initial EMS Certification Application
- EMS Out-of-State Reciprocity/Challenge Application
- Recertification Application

**1. Identification Information:**

Fill in your Department of Health credential number, telephone number, date of birth, name, and address.

**2. EMS Agency Association Requirement and EMS Supervisor:**

To be certified you must be associated with an EMS agency licensed by the Washington State Department of Health. Your EMS agency supervisor must complete this portion of the form.

**Note: You cannot sign for yourself as supervisor. Please have your supervisor sign and date the form.**

**3. County Medical Program Director (MPD):**

Follow the instructions from your local EMS coordinator or EMS agency supervisor to obtain your MPD's recommendation, signature and date. Your application is not complete until it is signed and dated by the MPD recommending you for certification.

**Additional Information:**

The EMS application process requires both this signature form and the appropriate Certification Application Packet.



# EMS Supervisor/Medical Program Director Signature Form

Check Appropriate Box:

<input type="checkbox"/> Initial	<input type="checkbox"/> Upgrade	<input type="checkbox"/> Reversion	<input type="checkbox"/> Reciprocity
<input type="checkbox"/> Challenge	<input type="checkbox"/> Recertification	<input type="checkbox"/> Reissuance	<input type="checkbox"/> Reinstatement
Certification Level (check one): <input type="checkbox"/> EMR <input type="checkbox"/> EMT <input type="checkbox"/> AEMT <input type="checkbox"/> Paramedic <input type="checkbox"/> Poison Information Specialist			

## 1. Identification Information

Name	First	Middle	Last
Birthdate (mm/dd/yyyy)	Phone (enter 10 digit #)	Email Address:	
Address			
City	State	Zip Code	County

## 2. EMS Agency Association Requirement and EMS Supervisor

Please provide the following information regarding your primary agency association:

Agency Name	Agency Credential Number	
Address		
City	State	Zip Code
Phone (enter 10 digit #)		
Contact Person Name	Contact Person Email	

“I affirm that if this applicant is certified, he/she will provide care with our EMS agency.”

\_\_\_\_\_

Printed Name of EMS Agency Supervisor                      Original Signature                      Date

## 3. County Medical Program Director (MPD)

The signature of the Washington State Medical Program Director (MPD) for the county where the applicant is providing care, or where his/her EMS agency is based, is required before state certification may be granted to this applicant.

“I recommend certification of this applicant based on the statements above, and the successful completion of the required examinations and/or evaluations. This applicant, if recommended for certification, has a copy of my county protocols.”

Protocol requirements do not apply to poison information specialists.

I do not recommend certification (attach a memo for details)

\_\_\_\_\_

Printed Name of County MPD                      Original Signature                      Date