



EMS Recertification Application Packet

Contents:

1. 530-119.... Contents List/SSN Information/ Mailing Information 1 page
2. 530-120.... General Instructions Checklist4 pages
3. 530-121.... EMS Recertification Application4 pages
4. 530-117.... EMS Supervisor/Medical Program Director Signature Form..... 2 Pages
5. RCW/WAC Links and Online Web Sites 1 page

Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, please contact customer service 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Send completed application and other documents to:

EMS Program
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

Include this blank page when printing two-sided.
Do **not** remove.

EMS Recertification Application Instructions Checklist

Important background check information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigations (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly in ink. It is your responsibility to submit the required forms.

Check Appropriate Box: Initial/Upgrade

- **Recertification:** A currently certified EMS provider within six months of their certification expiration date, requesting certification at the same level, for a second or subsequent time. Applicants can complete this paper application or complete their recertification through the [Online Renewal](#) process. See the recertification requirements in the “Additional Information” below.
- **Reissuance:** EMS providers with an expired certification may apply for reissuance by meeting the reissuance requirements. See the reissuance requirements in the “Additional Information” below.
- **Reinstatement:** Reinstatement is the process that must be completed when a person’s certification has modified, suspended, or revoked and wants to petition for reinstatement of the certification. See the reinstatement requirements in the “Additional Information” below.

1. Demographic Information:

Social Security Number: You **must** list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name with first, middle, and last.

Definition of legal name: “Legal name” is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Birth place: Provide the city, state, and country you were born in.

Address: List the address we should use to send any information on your credential. Be sure to include the city, state, zip code, and country. This will be your permanent record with Department of Health. You can ask us to change it. See [WAC 246-976-144 \(6\)](#) or [WAC 246-976-171 \(6\)](#).

Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change.

2. Personal Data Questions:

All applicants must answer the same personal data questions. These are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the questions. If you do not provide the documents, your application is incomplete and will not be processed.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can obtain copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

3. Professional and Educational Information:

Provide information as requested.

Education requirements for recertification:

Choose the method you met your continuing medical education (CME) requirements for your last certification period. If you select “Traditional CME”, you will need to successfully complete department approved knowledge and practical skill certification examinations. These are both required within 6 months prior to application. “OTEP” means an ongoing training and evaluation program, which is approved for specific EMS agencies by the Department of Health and County Medical Program Directors (MPD).

4. Applicant’s Attestation:

You must print your name and read the statement thoroughly to ensure you understand the provisions in this section. Provide the date and the city you are in then sign the statement. This must be complete in order for us to process your application.

5. Applicant’s Proof of Identity:

Attach to the application a current, legible photograph showing date of birth (DOB) ie., drivers’s license photo, passport, or military ID. The photograph must be clear and the information must be legible.

Additional Information:

Recertification: Applicant must be a currently certified EMT, AEMT or Paramedic within six months of their expiration date applying certification second or subsequent time .

The applicant must submit the following to your County MPD or MPD delegate with your application:

- Proof of meeting the recertification requirements below for the level of certification being sought:
 - CME method: [WAC 246-976-171](#), Table A.
 - OTEP method: [WAC 246-976-171](#), Table B.

Reissuance of an expired certificate: Provide the following to your County MPD or MPD delegate with your application:

- **If a certification is expired for one year or less:**
 - Proof of completing the recertification education requirements listed below for the applicant's certification period:
 - For EMS providers completing the CME method, complete the requirements identified in [WAC 246-976-171](#), Table A; or
 - For EMS providers completing the OTEP method, complete the requirements identified in [WAC 246-976-171](#), Table B; and
 - Proof of one year of annual recertification education requirements.
- **If a certification is expired more than one year and less than two years:**
 - Proof of completing the recertification education requirements listed below for the applicant's certification period:
 - For EMS providers completing the CME method, complete the requirements identified in [WAC 246-976-171](#), Table A; or
 - For EMS providers completing the OTEP method, complete the requirements identified in [WAC 246-976-171](#), Table B; and
 - One additional year of annual recertification education requirements; and
 - Twenty-four hours of educational topics and hours specified by the department and the MPD; and
 - For EMS providers completing the CME method, complete the requirements identified in Table A of this section; or
 - For EMS providers completing OTEP, complete the requirements identified in Table B of this section.
- **If a certification is expired for two years or longer:**
 - For nonparamedic EMS personnel:
 - Complete a department-approved initial training program, and successfully complete department-approved knowledge and practical skill certification examinations;
 - For paramedics whose certification has been expired between two and six years:
 - Current status as a provider or instructor in the following, ACLS, PHTLS, or BTLIS, PALS or PEPPS, or state approved equivalent;
 - Current status in health care provider CPR;
 - Completing a state approved forty-eight hour EMT-paramedic refresher training program or complete forty-eight hours of ALS training that consists of the following core content:
 - Airway, breathing and cardiology - sixteen hours.
 - Medical emergencies - eight hours.
 - Trauma - six hours.
 - Obstetrics and pediatrics - sixteen hours
 - EMS operations - two hours.

- Successful completion of any additional required MPD and department-approved refresher training;
 - Successful completion of MPD required clinical and field evaluations;
 - Successful completion of department-approved knowledge and practical skill certification examinations.
- **A request for reissuance of a paramedic certification that has been expired greater than six years will be reviewed by the department to determine the disposition**

Reinstatement of an expired certificate: A person whose EMS certification has been modified, suspended, or revoked may petition for reinstatement as provided in [RCW 18.130.150](#). The petitioner must:

- Provide proof of completion of all requirements identified by the departmental disciplinary authority; and
- Meet the reissuance requirements above.

Note: You cannot practice as emergency medical services until your certification is issued.

A completed EMS application consists of the following:

- EMS Recertification Application
- EMS Supervisor/Medical Program Director Signature Form



Background
Check
Stamp
Here

Date
Stamp
Here

EMS Recertification Application

Check Appropriate Box: Recertificaion Reissuance Reinstatement

Certification Level (check one): EMR EMT AEMT
 Paramedic Poison Information Specialist

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions.)

Name Male Female First Middle Last

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address

City	State	Zip	County
------	-------	-----	--------

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
--------------------------	------------------------	-------------------------

Email address

Mailing address (if different from above)

City	State	Zip	County
------	-------	-----	--------

Country

NOTE: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? Yes No

If yes, list name(s): _____

Will documents be received in another name? Yes No

If yes, list name(s): _____

For Office Use Only

Issuance Date _____ Credential # _____

Validation Date _____ Received Date _____

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.....

“Medical Condition” includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.
- 1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.....

“Currently” means within the past two years.

“Chemical substances” include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?.....

4. Are you currently engaged in the illegal use of controlled substances?.....

“Currently” means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ...

Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

- a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction

Note: If you answered “yes” to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

- b. If you answered “yes” to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete?
6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?
- b. Diverted controlled substances or legend drugs?
- c. Violated any drug law?
- d. Prescribed controlled substances for yourself?
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If “yes”, please attach an explanation and provide copies of all judgments, decisions, and agreements?
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?

3. Professional and Educational Information

1. Will you be primarily “paid” or “volunteer” EMS provider? Paid Volunteer
2. Are you active duty military or deployed? Yes No

3. Education requirements for recertification:

How have you met your continuing medical education (CME) requirements for the last certification period?

Please check **one**:

Traditional CME (Requires DOH EMS certification exam)

-or-

OTEP (Ongoing training & evaluation program)

EMT-IV, AEMT, and Paramedic level only - Have you successfully completed the skills maintenance requirements for your level of certification? Yes No

4. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of the state
(print applicant name clearly)
of Washington that the following is true and correct:

- ▶ I am the person described and identified in this application.
- ▶ I have read [RCW 18.130.170](#) and RCW [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- ▶ I have answered all questions truthfully and completely.
- ▶ The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
mm/dd/yyyy (city, state)

By: _____
Signature of Applicant

5. Applicant's Proof of Identity

Attach a copy of your official state or federal photo identification, such as military identification, drivers license, or passport.

EMS Supervisor/Medical Program Director Signature Form General Instruction Checklist

- 1. Identification Information:**
Fill in your Department of Health credential number, telephone number, date of birth, name and address. Your credential number can be found at [Provider Credential Search](#).
- 2. EMS Agency Association Requirement and EMS Supervisor:**
In order 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.

This form is required for each of the following applications:

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

EMS Supervisor/Medical Program Director Signature Form

1. Identification Information			
Department of Health Credential Number Your credential number can be found at Provider Credential Search .			
Name	First	Middle	Last
Birthdate (MM/DD/YYYY)	Phone	Email Address:	
Address			
City	State	Zip	County
2. EMS Agency Association Requirement and EMS Supervisor			
Please provide the following information regarding your primary agency association: Agency Name and Number: _____ Address: _____ Phone Number: _____ EMS Contact Person: _____ EMS Contact Email: _____ "I affirm that if this applicant is certified, he/she will provide care with our EMS agency." <div style="display: flex; justify-content: space-between; margin-top: 20px;"> _____ _____ _____ </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> Printed Name of EMS Agency Supervisor Original Signature Date </div>			
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. <input type="checkbox"/> "I recommend certification <input type="checkbox"/> I do not recommend certification (attach a memo for details) 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. <div style="display: flex; justify-content: space-between; margin-top: 20px;"> _____ _____ _____ </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> Printed Name of County MPD Original Signature Date </div>			

RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act.....	<u>RCW 18.130</u>
Administrative Procedure Act	<u>RCW 34.05</u>
Emergency Medical Services and Trauma System RCW	<u>RCW 18.71</u>
Emergency Medical Services and Trauma System RCW	<u>RCW 18.73</u>
Emergency Medical Services and Trauma System WAC.....	<u>WAC 246-976</u>

On-Line

Emergency Medical Services and Trauma System	<u>Web Page</u>
--	---------------------------------