Provisional - EMS Certification Application Packet

Contents:

Important Social Security Number Information:

If you have a Social Security Number, the law requires you to disclose it on your application for a professional or occupational license. 42 U.S.C. § 666(a)(13); RCW 26.23.150. It will be used under the state's child support enforcement program to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing support obligations. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. If you do not have a Social Security Number, you are still eligible to apply for and obtain a credential if you meet the requirements. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you have questions.

In order to process your request:

Send completed application and other documents to:

Department of Health
EMS Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

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Provisional 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 handwritten clearly in blue or black ink. It is your responsibility to submit the required forms.

☐ **Check the certification level:** EMR Provisional, EMT Provisional, AEMT Provisional, Paramedic Provisional.

☐ **Check if either apply:**
Request for Military Training and Experience Evaluation
Spouse or Registered Domestic Partner of Military Personnel

☐ **1. Demographic Information:**
Social Security Number: You must list your social security number on your application. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you have questions.
Legal Name: List your full name: 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.

Address: List the address we should use to send any information about your credential. Be sure to include the city, state, zip code, county, and country. This will be your permanent record with Department of Health until we have been notified of a change. 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 legal proof of this change. See WAC 246-12-300.

☐ **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.
- If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Provider Status:**
Answer the questions regarding your status in this section.

☐ **4. License, Certification, or Registration:**
List all states, including Washington, where health care provider credentials are or were held. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if credential is current. Attach additional completed pages if you need more space.

☐ **5. 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 city you are in, and then sign the statement. This must be complete in order for us to process your application.

☐ **6. Applicant’s Proof of Identity:**
Attach to the application a current, legible photograph showing date of birth (DOB) i.e., drivers license photo, passport, or military ID. The photograph must be clear and the information must be legible.

☐ **7. Applicant’s Proof of Current and Valid Certification:**
Attach a copy of current and valid National Registry of Emergency Medical Technicians (NREMT) certification and/or send proof of current and valid certification from another state.

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

For Current and Former Servicemembers Requesting Evaluation of Military Training and Experience

Under state law, your military education, training, and experience may count towards attaining certain civilian health care profession credentials in Washington State.

Submitted information will be reviewed by the Department of Health to determine substantial equivalency for meeting the credentialing requirements in this state.

Documents to submit with your health care professional credential application should include the following:

- If applicable, a copy of your DD214 Certificate of Release or Discharge from Active Duty, Member-4 or service 2 copy, or NGB-22 for National Guard.

  Please note:
  - A copy of your DD214 can be downloaded from the EBenefits website.
  - You can request a replacement copy of your NGB-22 on the National Archives website.
- Official Joint Service Transcript (JST) or Community College of the Air Force (CCAF) Transcripts.

  Please note:
  - JST can be sent electronically by visiting the JST website and selecting Washington State Department of Health.
  - CCAF transcripts cannot be sent electronically. See the CCAF website for transcript information.
- Verification of Military Experience and Training (VMET) or DD Form 2586. See the DoDTAP website.
- If applicable, application for the Evaluation of Learning Experiences During Military Service (DD Form 295). See the Military Resources website.

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Provisional Certification Requirements

Thank you for applying to become an Emergency Medical Services Provider in Washington State.

An individual may apply for a provisional certification to engage in supervised practice as a certified EMS provider for the level they have applied for.

Upon completion of any EMS service field training and MPD integration criteria, an applicant may apply for full certification.

All applicants must submit the following:

- ☐ Completed Application
- ☐ Proof of identity and age; a current, legible photograph showing date of birth (DOB) i.e., drivers's license photo, passport, or military ID. The photograph must be clear and the information must be legible.
- ☐ Completion of the EMS Supervisor/Medical Program Director Signature Form which shows proof of EMS Service affiliation and includes recommendation by the county medical program director.
- ☐ Other License, Certification, or Registration: Credential verifications must be requested by the applicant and submitted directly from every state. Verifications are valid for six months.
- ☐ Proof of current and valid National Registry of Emergency Medical Technicians (NREMT) certification or Proof of current and valid certification from another state.

Additional Information:

- The provisional certificate is valid for up to six months and is not renewable.
- You will be emailed a letter regarding any deficiencies if your application is incomplete.

Note: You cannot practice as emergency medical services provider until your certification is issued, and you have affiliation with an EMS service credentialed in Washington State.

Applying for your EMS Certification after completion your EMS service field training and MPD integration criteria.

- ☐ Completed EMS Certification Application Packet
- ☐ Completion of the EMS Supervisor/Medical Program Director Signature Form which shows proof of EMS Service affiliation and includes recommendation by the county medical program director.
- ☐ License, Certification, or Registration: Credential verifications must be requested by the applicant and submitted directly from every state.

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Washington State Department of HEALTH

Date Stamp Here

Provisional EMS Certification Application

Certification Level: ☐ EMR Provisional ☐ EMT Provisional ☐ AEMT Provisional ☐ Paramedic Provisional

Select if either apply: ☐ Request for Military Training and Experience Evaluation
☐ Spouse or Registered Domestic Partner of Military Personnel

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	☐ Male ☐ Female ☐ Prefer Not to Answer ☐ X

Name
Last First Middle

Birth date (mm/dd/yyyy)

Address

City	State	Zip Code	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 Code	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):

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, intellectual disabilities, 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.

If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.

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

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? ☐ ☐
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? ☐ ☐

3. Provider Status

1. Will you be primarily "paid" or "volunteer" EMS provider? ☐ Paid ☐ Volunteer
2. Have you earned a high school diploma or GED certificate? (EMR exempt) ☐ Yes ☐ No
3. Are you active duty military or deployed? ☐ Yes ☐ No

4. License, Certification, or Registration

List all states in which you hold or have held a health care license, certification, or registration.

State	Profession	License Type	License YR issued	License Number	Method of License	Currently in Force
						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes

5. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of the state
(Name of Applicant)

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 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.

By: _____ Dated _____
(Signature of Applicant) (mm/dd/yyyy)

6. Applicant's Proof of Identity

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

7. Applicant's Proof of Current and Valid Certification

Attach a copy of current and valid National Registry of Emergency Medical Technicians (NREMT) certification and/or send proof of current and valid certification from another state.

General Instructions Checklist

Provisional - EMS Supervisor/Medical Program Director Signature Form

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

- Provisional EMS Certification Application

☐ **1. Identification Information:**

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

☐ **2. EMS Service Affiliation Requirement and EMS Supervisor:**

To be certified you must be affiliated with an EMS service licensed by the Washington State Department of Health. Your EMS service 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 service 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 Provisional EMS application process requires both this signature form and the appropriate Certification Application Packet.

An individual may apply for a provisional certification to engage in supervised practice as a certified EMS provider for the level they have applied for.

The provisional certificate is valid for up to six months and is not renewable.

Upon completion of any EMS service field training and MPD integration criteria, an applicant may apply for full certification.

Provisional EMS Supervisor/Medical Program Director Signature Form

Check appropriate box:

Certification Level: ☐ EMR Provisional ☐ EMT Provisional ☐ AEMT Provisional ☐ Paramedic Provisional

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 Service Affiliation Requirement and EMS Supervisor

Please provide the following information regarding your primary service affiliation:

EMS Service Name	EMS Service 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 service and our EMS service is following requirements listed in provisional emergency services provider certification - eligibility RCW 18.71.097."

Printed Name of EMS Service 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."

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

Printed Name of County MPD	Original Signature	Date

EMS Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Credential Verification

To be completed by the applicant:
Please complete the top section of this form and send it to the state(s) and/or jurisdiction(s) where you are or have been licensed, certified, or registered as a healthcare provider. Instruct them to send the form directly to the address listed above.

Note: Credentialing agencies may require a fee to verify a license, registration or certification. Check in advance to help expedite the process.

Name: Last	First	Middle
Mailing Address		
City	State	Zip Code
License, Certification, or Registration Number		
I authorize the release of the information below to the Washington State Department of Health. Signature:		

To be completed by the regulatory agency:
Please complete this form regarding the applicant listed above. Submit the completed form and any other requested material directly to this office at the address above. We will not accept the form if submitted by the applicant.

Name of license, certification, or registration holder		
License, certification, or registration number	Issue Date	Expiration Date
License, certification, or registration status	Method of licensure, certification, or registration	
Has the individual ever had any disciplinary action in your state? ☐ Yes ☐ No If yes, please attach an explanation and provide a copy of the final order or other documentation of action taken.		

(SEAL)

Signature: _____

Title: _____

Name of regulatory agency _____

Date: _____

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RCW/WAC and Online Website Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Emergency Medical Services and Trauma System, RCW 18.71

Emergency Medical Services and Trauma System, RCW 18.73

Emergency Medical Services and Trauma System, WAC 246-976

Online

Emergency Medical Services and Trauma System Web Page