EMS Personal Status Changes Application Packet

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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, contact the Customer Service Center at 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:

Complete the application following the Application Instructions Checklist on page one. Get all signatures before sending the application to the address below.

Mail your application and other documents to:

Department of Health
EMS Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

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Washington State Department of Health

Application Instructions Checklist

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

☐ **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: 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 license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the 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 proof of this change. See WAC 246-12-300.

☐ **2. Personal Status Changes:**

Select all changes that apply.

- **Add Agency:** You will keep your current EMS agency of record, and want to add another EMS agency to your record.
- **Change Agency:** You are no longer with your previous EMS agency, and want to change to a different EMS agency of record.
- **Change Address:** Your personal address of record has changed.
- **Change Name:** The name under which you have been legally known has changed. Provide legal documentation i.e., marriage license, court order, valid photo I.D., Social Security Card, etc. Include your previous name where indicated.

☐ **3. EMS Supervisor Statement:**

The supervisor statement is required when changing and or adding agencies.

- Fill in the name and license number of the EMS agency you are adding or changing to. If you do not know the agency license number, ask your supervisor.
- Obtain the signature and date of your EMS supervisor with this agency.
- Indicate whether you are Paid or Volunteer with this agency.
- Indicate whether this will be your primary agency. “Primary” is the agency where you obtain the majority of your EMS activity and continuing medical education (CME) credits.

☐ **4. County Medical Program Director (MPD) Statement:**

The county medical program director statement is required when changing and or adding counties, and when a provider returns to active agency affiliation.

☐ **5. Applicant Attestation:**

You must sign and date this for us to process your application.

Information regarding EMS Program is available on our **Web Site**.

Note: The application is valid for one year from the date the applicant signs the form.

Washington State Department of Health

Personal Status Changes Application

1. Demographic Information

Department of Health Credential Number			Social Security Number
Name ☐ Mr. ☐ Ms. First	Middle		Last
Birthdate (MM/DD/YYYY)	Phone (Enter 10 digit #)		Email Address:
Address			
City	State	Zip Code	County

2. Personal Status Changes

Personal Status Changes: (Please select all that apply.)

☐ Add Agency ☐ Change Agency ☐ Change Address ☐ Change Name (documentation required)

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

If yes, list name(s):____

3. EMS Supervisor Statement

The EMS supervision statement is required when changing and or adding agencies.

"I attest this applicant will provide care with our EMS agency."

______________________________ ______________________________

Agency Name License Number

______________________________ ______________________________

EMS Supervisor's Original Signature Date

1. Employment Status with this Agency: (please select one) ....☐ Paid ☐ Volunteer
2. Will this be Primary Agency?: (please select one)...☐ Yes ☐ No

4. County Medical Program Director (MPD) Statement

The county medical program director statement is required when changing and or adding counties, and when a provider returns to active agency affiliation.

☐ "I recommend ☐ I do not recommend"

State certification of this applicant in my county. Applicants recommended for certification have a copy of my protocols.

____

MPD's Written Name MPD's Original Signature Date

5. Applicant's Attestation

I,_______________________________________, declare under penalty of perjury under the laws of the state of
(Name of Applicant)
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 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: ______________________________
(Original Signature of Applicant)

RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act.. **RCW 18.130**

Administrative Procedure Act .... **RCW 34.05**

Emergency Medical Services and Trauma System RCW .... **RCW 18.71**

Emergency Medical Services and Trauma System RCW .... **RCW 18.73**

Emergency Medical Services and Trauma System WAC........................... **WAC 246-976**

On-Line

Emergency Medical Services and Trauma System..**Web Page**