



## **Emergency Medical Services (EMS) Evaluator Application Packet**

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### **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](mailto:doh.information@doh.wa.gov).

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## Application Instructions Checklist

Thank you for your application for EMS Evaluator. All information should be 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. 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 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.

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

**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 Department of Health until we have been notified of a change. See [WAC 246-12-310](#).

**Phone, Fax, and Cell Numbers:** Enter your phone, fax, and cell numbers, if you have them.

**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. Education Attestation:**

You must certify that you have a minimum of three years’ experience practicing as a state certified EMS provider at or above the level of certification being evaluated. NREMT certification does not apply towards the three-year requirement as an experienced provider

**3. Training Course Attestation—To be completed at renewal only:**

Sign this if you are not providing a certificate of completion.

**4. Medical Program Director Attestation:**

Provide the printed name of your County Medical Program Director (MPD) and obtain their signature.

**5. Applicant’s Attestation:**

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

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## **EMS Evaluator Requirements**

Thank you for applying to become an EMS Evaluator in Washington State. To expedite the license process, please use the following checklist to ensure you have completed all requirements.

### **To apply to become a certified EMS Evaluator, applicants must:**

- Complete an application on forms provided by the Department.
- Hold a current Washington State EMS Certification.
- Have a minimum of three years experience at or above the level of certification being evaluated.
- Be current in continuing medical education and ongoing training requirements for their primary EMS certification.
- Provide a certificate of completion as proof of an MPD approved initial EMS evaluator course within the past three years.
- Be recommended by the county medical program director. The county medical program director must sign the application.

### **To renew an EMS Evaluator certification, applicants must:**

- Complete an application on forms provided by the Department.
- Hold a current Washington State Certification.
- Be current in continuing medical education and ongoing training requirements for their primary EMS certification.
- Complete a department approved EMS evaluator refresher course within the past three years.
- Be recommended by the county medical program director. The county medical program director must sign the application.

**Note:** An ESE whose recognition has expired for more than three years must complete the initial recognition process.

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Date  
Stamp  
Here

## Emergency Medical Services (EMS) Evaluator Application

Please print clearly. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

**Select One:**

Initial Certification     Renewal

### 1. Demographic Information

**Social Security Number (SSN)** (If you do not have a SSN, see instructions)

Male     Female  
 Prefer not to answer  
 X

Name	First	Middle	Last
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Birth date (mm/dd/yyyy)

**Place of birth**

City	State	Country
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Address

City	State	Zip Code	County
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Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
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Email Address:

Mailing address (if different from above)

City	State	Zip Code	County
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Country

**Note:** The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the Department of Health.

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. Experience Attestation

I certify that I have a minimum of three years of experience practicing as a state certified EMS provider at or above the level of certification being evaluated. NREMT certification does not apply towards the three-year requirement as an experienced provider.

Applicant's Initials	Date

## 3. Training Course Attestation (Renewal Applicants Only)

I certify that I have successfully completed a department and MPD approved ESE Evaluator Refresher Course.

Applicant's Initials	Date

## 4. Medical Program Director Attestation

I verify that the applicant has demonstrated proficiency in performing skills at the level of certification that the applicant will be evaluating and that the applicant is current in continuing education requirements for his/her primary certification.

- I recommend this applicant receive ESE Certification.  
 I do not recommend this applicant receive ESE Certification.

Comments:

County Medical Program Director (MPD): \_\_\_\_\_ Date: \_\_\_\_\_  
Print Name

MPD Original Signature \_\_\_\_\_



## 5. Applicant's Attestation

I, \_\_\_\_\_, declare under penalty of perjury under the laws of the  
(Print applicant name clearly)  
state 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

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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](#)

[Administrative Procedures and Requirements, WAC 246-12](#)

[Emergency Medical Services and Trauma Care Systems, WAC 246-976](#)

[Emergency Medical Services Evaluator Initial Requirements, WAC 246-976-031](#)

[Emergency Medical Services Evaluator Renewal Requirements, WAC 246-976-032](#)

### **Online**

[Emergency Medical Services Web Page](#)