EMS Expired Reissuance 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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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 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.

National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

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. We will use the email address provided as the primary contact source to update you on the status of your application. It is important to ensure your email address is correct and current at all times.

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. Provider Status:**
Provide information about your status as a provider.

☐ **3. Continuing Medical Education (CME):**
Provide the county MPD proof of successful completion of education and skill requirements prescribed in **WAC 246-976-161**. You do not need to submit documentation of your training to the department unless requested.

Education requirements for recertification:
Choose the method used to meet your continuing medical education (CME) requirements for your last certification period.

- If you select “Traditional CME”, you will need to successfully complete a department approved knowledge examination.
- If you select“OTEP”, an ongoing training and evaluation program, you will need to successfully complete a Department of Health and County Medical Program Directors (MPD) approved OTEP plan with your primary EMS service.

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

☐ **6. Current and Valid Certifiction:**
Attach a copy of your current and valid certification from another state and/or National Registry of Emergency Medical Technicians (NREMT) if Washington State certification is expired more than two years.

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

Certification Requirements:

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

☐ **If a certification is expired for two year or less:**

Proof of successful completion of education and skill requirements prescribed in **WAC 246-976-161**;

Complete any additional MPD required education and skills competency checks;

For applicants seeking reissuance by meeting the CME recertification requirements prescribed in **WAC 246-976-162**:

- Proof of successful completion of education and skill requirements; and
- Proof of successful completion of the department-approved knowledge examination withini the current certification period;

For applicants seeking reissuance by meeting the OTEP recertification requirements prescribed in **WAC 246-976-163**:

- Successfully complete a department-approved OTEP program; and
- Provide the county MPD proof of successful completion of education and skill requirements.

☐ **If a certification is expired for two years or longer:**

- Provide proof of a current and valid certification from another state and/or National Registry of Emergency Medical Technicians (NREMT).
- Complete any additional MPD required education and skills competency checks.

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

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Washington State Department of HEALTH

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EMS Expired Reissuance Application

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

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

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. Provider Status

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

3. Continuing Medical Education (CME)

1. Choose the method you used to meet your continuing medical education (CME) requirements for you last certification period.

Please check one:

☐ Traditional CME (Requires DOH EMS certification exam) -or-

☐ OTEP (Ongoing training & evaluation program)

2. Successful completion of the skills maintenance requirements for your level of certification as listed in WAC 246-976-161. ☐ Yes ☐ No

4. License, Certification or Registration

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

State	Profession	License Type	License		Method of License	Currently in Force
			YR issued	Number		
						☐ 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.

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

6. Current and Valid Certification (required if expired over 2 years)

If expired more than 2 years, attach a copy of your current and valid certification from another state and/or National Registry of Emergency Medical Technicians (NREMT).

7. Applicant's Proof of Identity

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

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General Instruction Checklist EMS Supervisor/Medical Program Director Signature Form

This form is required to be submitted with all applications.

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

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

Washington State Department of HEALTH

EMS Supervisor/Medical Program Director Signature Form

Check Appropriate Box:

☐ Initial ☐ Upgrade ☐ Reversion ☐ Reciprocity ☐ Challenge

☐ Recertification ☐ Reissuance

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

1. Identification Information

Department of Health Credential Number

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 agency association:

Service Name and Number: _____

Address: _____

Phone (enter 10 digit #): _____

EMS Contact Person: _____

EMS Contact Email: _____

"I affirm that if this applicant is certified, he/she will provide care with our EMS service."

Printed Name of Supervisor Signature	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 service 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

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 Requirements, WAC 246-976-032

Online

Emergency Medical Services Web Page