



North Dakota Department of Health  
 Division of Emergency Medical Services  
 600 E Boulevard Ave Dept 301, Bismarck ND 58505-0200

**EMERGENCY MEDICAL TECHNICIAN - PARAMEDIC  
 LICENSE/RENEWAL APPLICATION**

Name: \_\_\_\_\_ State License # \_\_\_\_\_

National Registry # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

E-Mail address: \_\_\_\_\_

Home Phone# \_\_\_\_\_ Work Phone# \_\_\_\_\_ Cell Phone# \_\_\_\_\_

Agency Affiliation: \_\_\_\_\_

Have you ever had a health care license or certification terminated or suspended?  Yes  No

Have you been charged with or convicted of a felony?  Yes  No If yes to either, provide documentation.

I attest to the accuracy of the above statements and give the Health Department permission to perform a criminal background check.

\_\_\_\_\_  
 (Signature Required)

**MEDICAL DIRECTOR AGREEMENT**

The above named person is employed by an ambulance service, rescue squad, or health care setting for which I am the Medical Director.

Upon state licensure as a Paramedic by the North Dakota Department of Health of the person named above, I will provide medical direction consisting of verbal, written, or standing orders allowing the above named person to provide medical care consistent with the skills defined by the North Dakota Scope of Practice for Paramedics.

I will assure that the person named above continues to remain competent in the skills contained in the North Dakota Scope of Practice for Paramedics. I have complete discretion as to which skills or treatment modalities listed in the North Dakota scope of practice for EMS providers the above named person may provide during the normal course of his/her duties.

I understand that the above named person is allowed to provide patient care to the level of a Paramedic as part of my practice, and only as a result of my delegation of the authority to do so. I further understand that I may revoke this authority at any time. If I revoke this authority, I will provide the Division of Emergency Medical Services with written notification of the revocation.

**THIS AGREEMENT EXPIRES UPON TERMINATION FROM THE ABOVE NAMED AGENCY OR 90 DAYS AFTER THE NATIONAL REGISTRY CARD EXPIRATION:**

\_\_\_\_\_  
 (Physician Medical Director of above named Agency)

\_\_\_\_\_  
 (Signature of Physician)

\_\_\_\_\_  
 (Medical License Number)

\_\_\_\_\_  
 (Date)

**DEMS OFFICE USE ONLY:**

National Registry Expiration \_\_\_\_\_

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SFN 17393 (10/90--R02/91-10/93-12/94-12/95-09/99-10/00-12/00- 08/01- 7/03- 9/03—1/06)

**RETURN THIS FORM TO:**  
 Emergency Medical Services  
 North Dakota Department of Health  
 600 E Boulevard Ave. Dept 301  
 Bismarck ND 58505-0200