



2006

EMS REGISTRATION

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES
Telephone (701) 328-2388 / Fax (701) 328-1890
SFN 52195 (1-06)



INSTRUCTIONS: Type or print clearly. This form is to be submitted at the beginning of each course or as needed to update information in the DEMS registry. Return one completed copy to: ND Department of Health, Division of Emergency Medical Services, 600 E Boulevard Ave. Dept. 301, Bismarck, ND 58505-0200. Keep a copy for your records.

National Registry Number:		State ID #:	
<input type="radio"/> Mr. First Name <input type="radio"/> Mrs. <input type="radio"/> Ms		Last Name:	Middle Initial:
Date of Birth:	Social Security Number	Email Address:	
Mailing Address:		City:	State: Zip:
County:		Service Code # (3 digit number)	
Work Telephone Number:	Home Telephone Number:	Cell Phone Number:	

Have you ever been charged or convicted with a felony? Yes No
 Have you ever had a health care licensure or certification terminated or suspended? Yes No
If any of the above have been marked yes, please provide official documentation that fully describes the offense, current status, and disposition of the case

EMS Provider Level

Driver CPR First Responder EMT-B EMT-I 85 EMT-I 99 EMT-P
 LPN RN Other (Please Specify):

Privacy Act Notification

Your social security number is requested to permit the North Dakota Department of Health to verify national registration and to properly conduct a background investigation pursuant to N.D.A.C. section 33-36-01-05 before issuing a certification. Disclosure of your social security number is voluntary. However, not providing this information may result in delay of issuance of a certification due to misidentification or criminal records check requirements of state, local or federal agencies, or identification requirements of the National Registry of Emergency Medical Technicians.

I hereby affirm and declare that the above information is true and correct and that any fraudulent entry may be considered a sufficient cause for rejection or revocation. I also understand that fraudulent entries may be considered a crime and may be prosecuted under State Law. I further agree to notify the ND State Health Department Division of Emergency Medical Services immediately if any changes in status occur. I also give permission to the Division of Emergency Medical Services to perform a criminal background check if required.

Signature _____ **Date** ____ / ____ / ____

Notice

Please submit EMS Registration forms for each student at the start of each course to ensure eligibility for course completion and completion of the testing process.