2015 ALS PROVIDER LICENSE / RENEWAL APPLICATION

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES & TRAUMA
SFN 17393 (1/2015)

*This form **must** be completed in its entirety or it will be returned*. This form is required for all advanced level EMS personnel as application for state licensure and/or re-licensure. An application must be submitted for each agency affiliation. An EMS registration form is not required for ALS personnel.
Return to: ND Department of Health, Division of EMS and Trauma; 600 E Boulevard Ave - Dept 301; Bismarck ND 58505-0200; Fax: 701.328.1702

Level	☐ **EMT-Intermediate/85**	☐ **EMT-Intermediate/99**	☐ **AEMT**	☐ **Paramedic**

State EMS Number	Social Security Number	National Registry Number

First Name	Last Name	MI

Home Address / PO Box	City	State	Zip Code

County	E-Mail Address	☐ Male	☐ Female

Date of Birth	EMS Agency Affiliation	◯ Continued Affiliation ◯ Additional Affiliation	◯ Replacement Affiliation

Home Telephone Number	Work Telephone Number	Cell Phone Number

Do you receive monetary compensation as an EMS Provider? ☐ Yes ☐ No | If so do you receive more than $10,000.00 per year? ☐ Yes ☐ No

1. **Have you ever been charged or convicted with a felony?** ☐ Yes ☐ No
2. **Have you ever been subject to limitation, suspension, or termination of your right to practice in a health care occupation or voluntarily surrendered a health care licensure in any state?** ☐ Yes ☐ No
3. **If yes to either 1 or 2, have you previously submitted this information / documentation to DEMST?** ☐ Yes ☐ No

If 1 or 2 above have been marked yes, provide official documentation that fully describes the offense, current status,and disposition of the case if you have not submitted to DEMST in the past. This section **must be completed or form will be returned.*

PRIVACY ACT STATEMENT

Your social security number is requested to permit the North Dakota Department of Health to verify eligibility to become nationally registered and to properly conduct a background investigation pursuant to N.D.A.C section 33-36-01-05 before issuing licensure or certification. Disclosure of your social security number is voluntary, however, not providing this information may result in a processing delay due to misidentification 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 fraudulent entries may be 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 Department of Health Division of Emergency Medical Services and Trauma immediately if any changes in my status should occur. I also give permission to the Division of Emergency Medical Services and Trauma to perform a criminal background check.

Signature	Date

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 an Advanced Level EMS Professional 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.
I will assure that the person named above continues to remain competent in the skills contained in the North Dakota scope of practice. 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 licensure as a 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 and Trauma with written notification of the revocation.

This agreement expires upon termination from the above named agency or 90 days after National Registry Expiration.

Medical Director Signature	License Number	Date

Signature of squad leader / manager required ONLY when adding personnel to EMS agency roster.

Signature of listed agency's squad leader / manager on record	Date

Print, sign and submit to DEMST