

STATE VERIFICATION

OF EMERGENCY MEDICAL SERVICES
 LICENSURE AND/OR CERTIFICATION

TO BE COMPLETED BY THE APPLICANT, THEN SEND TO THE STATE AGENCY IN WHICH YOU HAVE HELD CERTIFICATION

NAME:
FIRST MIDDLE LAST

NREMT CERTIFICATION NUMBER: DATE (mm/dd/yyyy):

STATE OF CERTIFICATION/LICENSURE: CERTIFICATION/LICENSE # :

NUMBER OF STATES, OTHER THAN MA, IN WHICH YOU HAVE HELD EMT CERTIFICATION/LICENSURE (VERIFICATION FORMS REQUIRED FROM EACH)

ARE YOU SUBMITTING YOUR INITIAL MASSACHUSETTS APPLICATION ONLINE (E-LICENSING) OR BY PAPER (MAIL):

TO BE COMPLETED BY THE STATE EMS OFFICE

The above named individual is applying for Massachusetts EMT certification and reported holding **current and/or prior** credentials from your agency. Please complete the following information regarding all current and/or prior certifications which your agency has issued a credential for and **return it directly to our office**. Please call 617-753-7300 with any questions or concerns. If submitting alternative documentation, please include a copy of this form when sending to Massachusetts.

	CERTIFICATION NUMBER	ISSUE DATE	EXPIRATION DATE	NOTES / COMMENTS
EMT/EMT-BASIC				
EMT-I 85/99				
ADVANCED EMT				
PARAMEDIC/EMT-PARAMEDIC				
Other: _____				

<p>Is this applicant's certification/license in good standing? (No compliance issues on the record and no pending compliance issues)</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO (please attach documentation of the incident)</p>	<p>Has this applicant's certification/license ever been suspended and/or revoked in your state?</p> <p><input type="checkbox"/> YES (please attach documentation of the incident) <input type="checkbox"/> NO</p>
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INDIVIDUAL VERIFYING (PRINT)	TITLE
INDIVIDUAL VERIFYING (SIGNATURE)	DATE
(STATE) LICENSING AGENCY	PHONE NUMBER

PLEASE RETURN THIS DOCUMENT DIRECTLY TO MASSACHUSETTS OEMS BY EMAIL, FAX, OR MAIL	
EMAIL: oems.recert@state.ma.us FAX: 617-753-7320	MASSACHUSETTS DPH-OEMS EMS CERTIFICATION (VERIFICATION) 67 FOREST STREET MARLBOROUGH MA 01752