



**Rhode Island Department of Health  
Division of Emergency Medical Services**

3 Capitol Hill , Room 103  
Providence, RI 02908-5097

*Application For*

***License as an  
Emergency Medical Technician***

Select the level of EMT Licensure you are applying for (check one):

**EMT**

**EMT-Cardiac (EMT-C)**

**Paramedic**

*Applicant - Print Name (First/MI/Last)*

**\*Do Not Hand Deliver - Application Must Be Mailed\***

FOR DEPARTMENT OF HEALTH USE ONLY

Approved

Denied

Date \_\_\_\_\_

By \_\_\_\_\_

EMT# \_\_\_\_\_

Expiration Date: \_\_\_\_\_

**Phone: (401) 222-2401**

**TTY/TDD: (800) 745-5555**

**Fax: (401) 222-3352**

Revised 10/02/2013 jcp

# GENERAL INFORMATION

1. Requirements for EMT licensure are established by the Rules and Regulations Relating to Emergency Medical Services (R23-4.1EMS), available through the Division of EMS website at <http://www.health.ri.gov>
2. EMT licensure can be denied pursuant to the provisions of the Rules and Regulations Relating to Emergency Medical Services (R23.4.1EMS). False/incorrect statements or documents may be considered sufficient cause to deny or revoke a license as an EMT in Rhode Island and may result in additional penalties as determined by law. The Department may conduct random application audits, requiring the EMT applicant to file proof of completion of the above training requirements for renewal.
3. Should you have any questions regarding the EMT license requirements or completion of the application form, contact the Division of Emergency Medical Services at (401) 222-2401.

➔ **PLEASE NOTE: This application form (dated 01/31/2011) supplants all previous versions. Prior versions of the application will not be accepted or processed.**

## APPLICATION INSTRUCTIONS

1. Complete all application materials as instructed. Please answer all questions. Incomplete questions or incomplete applications will not be processed. Please mark "NA" on questions that are Not Applicable.
  2. Do not detach any full pages from this booklet.
  3. Please type this application using the fillable form online then print the completed form.
  4. Sign the application and return it with the required fee(s). Do not submit the application without all applicable information, documentation and fee(s).
  5. Mail the completed application to: (Do Not Hand Deliver)  
Rhode Island Department of Health  
Division of Emergency Medical Services  
Room 103, 3 Capitol Hill  
Providence RI 02908-5097
- Please note: Extra postage will be required.
6. **Faxed applications WILL NOT be accepted.**
- PERSONAL CHECKS WILL NOT BE ACCEPTED. PAYMENT MUST BE A (CASHIER'S CHECK OR MONEY ORDER)**

## REQUIRED DOCUMENTATION

1. **ALL** applicants at any level must submit an **ORIGINAL** Bureau of Criminal Identification (BCI) report. Rhode Island residents shall obtain this information from the RI Attorney General's Office, 150 South Main Street, Providence, RI 02903. Tel. (401) 421-5268. Out-of-state applicants should obtain their full BCI report from their state of residence. If an offense occurred in another state, a full BCI will also be required from the state in which the offense occurred.
  2. Photostatic copy (front and back) of a **current - signed** Healthcare Provider level or equivalent cardiopulmonary resuscitation (CPR) card eg. (American Heart Association Healthcare Provider, American Red Cross Professional Rescuer, American Safety and Health Institute CPRPRO, Medic First Aid BLSPRO, or National Safety Council Professional Rescuer CPR). **This card must be signed.**
  3. **For First-Time Applicants** - photostatic copy of High School Diploma or GED
  4. Photostatic copy of diploma or certificate from the sponsoring agency/school verifying completion of the EMT training program specific to the level of licensure application.
  5. **EMT and Paramedic Applicants** - photostatic copy of current NREMT Registration
- In Addition to 1-5 Out of State Applicants Must Also Complete 6-10**
6. Documentation of EOA-PASG (MAST) training (Out of State applicants only)
  7. Photostatic copy of EMT license from a state other than Rhode Island, if applicable.
  8. Photostatic copy of current registration with the National Registry of Emergency Medical Technicians if applying for EMT or Paramedic By Endorsement.
  9. Interstate Verification Form completed by each state (other than Rhode Island) in which the applicant has been licensed and/or trained as an EMT (if applicable).
  10. Out-of-state applicants should obtain their full BCI report **from their state of residence.**

**IMPORTANT: Licensure is an individual responsibility and NOT the responsibility of your employer or supervisor.**



# State of Rhode Island

## Division of Emergency Medical Services

Application for License as an Emergency Medical Technician

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

### 1. Name(s)

This is the name that will be printed on your license and reported to those who inquire about your license. Do not use nicknames, etc.

	<input style="width: 100%;" type="text"/> <small>Title (i.e., Mr., Mrs., Ms., etc.)</small>
	<input style="width: 100%;" type="text"/> <small>First Name</small>
	<input style="width: 100%;" type="text"/> <small>Middle Name</small>
	<input style="width: 100%;" type="text"/> <small>Surname, (Last Name)</small>
	<input style="width: 100%;" type="text"/> <small>Suffix (i.e., Jr., Sr., II, III)</small>
	<input style="width: 100%;" type="text"/> <small>Maiden, if applicable</small>
	Name(s) under which originally licensed in another state, if different from above (First, Middle, Last). <input style="width: 100%; height: 20px;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/>

### 2. Social Security Number

<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
<small>U.S. Social Security Number</small>											

### Mandatory Information

### 3. Gender

Male       Female

### 4. Date of Birth

<input style="width: 100%;" type="text"/> <small>Month</small>	<input style="width: 100%;" type="text"/> <small>Day</small>	<input style="width: 100%;" type="text"/> <small>Year</small>
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### 5. Home Address

It is your responsibility to notify the EMS Office of all address changes.

<input style="width: 100%;" type="text"/> <small>1st Line Address (Apartment/Suite/Room Number, etc.)</small>			
<input style="width: 100%;" type="text"/> <small>Second Line Address (Number and Street)</small>			
<input style="width: 100%;" type="text"/> <small>City</small>	<input style="width: 100%;" type="text"/> <small>State</small>	<input style="width: 100%;" type="text"/> - <input style="width: 100%;" type="text"/> <small>Zip Code</small>	
<input style="width: 100%;" type="text"/> <small>Country, if NOT U.S.</small>		<input style="width: 100%;" type="text"/> <small>Postal Code, if NOT U.S.</small>	
<input style="width: 100%;" type="text"/> - <input style="width: 100%;" type="text"/> <small>Home Phone</small>	<input style="width: 100%;" type="text"/> - <input style="width: 100%;" type="text"/> <small>Home Fax</small>		
<input style="width: 100%;" type="text"/> <small>Email Address (Format for email address is Username@domain e.g. applicant@isp.com)</small>			

### 6. Rhode Island License

Please provide information concerning your previous licensure in the State of Rhode Island, if applicable.

Have you **ever** been licensed as an EMT in Rhode Island?  Yes  No

If the answer to this question is **"yes"**, provide license number, and if applicable, enter all other state abbreviation(s) of EMT licenses you hold or may have held in Question 7.

**Rhode Island License Number**

E	M	T				
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License Number

**7. Other State Licensure**

List all states or countries in which you are now or ever have been licensed to practice as an EMT.

**YOU must send a copy of the Interstate Verification Form to each entity (see page 10).**

State/Country:

\_\_\_\_\_  Active  Inactive  
 \_\_\_\_\_  Active  Inactive  
 \_\_\_\_\_  Active  Inactive  
 \_\_\_\_\_  Active  Inactive  
 \_\_\_\_\_  Active  Inactive

State/Country:

\_\_\_\_\_  Active  Inactive  
 \_\_\_\_\_  Active  Inactive  
 \_\_\_\_\_  Active  Inactive  
 \_\_\_\_\_  Active  Inactive  
 \_\_\_\_\_  Active  Inactive

**8. EMT Training Program Information**

Please enter the Last Name and License Number of the Instructor-Coordinator who provided you with your EMT training. Also, provide the name of the Sponsoring Agency, the dates of the training program and the Course Approval Number.

\_\_\_\_\_

Last Name of Instructor-Coordinator

**E M T** \_\_\_\_\_

License Number of Instructor-Coordinator

**Note: The EMS Instructor-Coordinator's License Number is the same as their RI EMT License Number**

\_\_\_\_\_

Sponsoring Agency

\_\_\_\_ Month      \_\_\_\_ Day      \_\_\_\_ Year

\_\_\_\_ Month      \_\_\_\_ Day      \_\_\_\_ Year

\_\_\_\_\_ - \_\_\_\_\_

Course Approval Number

**Note: The Course Approval Number was given to you at the start of your training course. It may be obtained by contacting the EMS Licensed Instructor-Coordinator who provided your training.**

**9. Disaster Availability**

I am interested in becoming a volunteer emergency responder during a disaster or state of emergency.

Yes  No

**10. Rhode Island EMS/Dept/Service Affiliation**

Please list only ONE affiliation. If you have no affiliation, please mark question as NA.

\_\_\_\_\_

Rhode Island EMS Department/Service Affiliation

\_\_\_\_\_

1st Line Address (Department/Suite/Room Number, etc.)

\_\_\_\_\_

Second Line Address (Number and Street)

\_\_\_\_\_

City

\_\_\_\_\_

Country, If NOT U.S.

\_\_\_\_\_ - \_\_\_\_\_

Business Phone

\_\_\_\_ State      \_\_\_\_ Zip Code      - \_\_\_\_\_

State

Zip Code

\_\_\_\_\_

Postal Code, If NOT U.S.

\_\_\_\_ Business Fax      \_\_\_\_ - \_\_\_\_\_

Business Fax

**11. Dept/Service Affiliation Verification**

To be completed by Chief of department or service.

I hereby certify that \_\_\_\_\_ is a bonafide member of my

EMS Service/Department and that said affiliation is true and accurate.

Printed Name of Chief

\_\_\_\_\_

Signature of Chief

\_\_\_\_\_

Date of Signature

**12. Criminal Convictions**

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending?

Yes  No

Abbreviation of State and Conviction<sup>1</sup> (e.g. CA - Illegal Possession of a Controlled Substance):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Month		Year	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**ALL** applicants at any level must submit an **Original Bureau of Criminal Identification (BCI) report**. Rhode Island residents shall obtain this information from the RI Attorney General's Office, 150 South Main Street, Providence, RI 02903. Tel. (401) 421-5268. Out-of-state applicants should obtain their full BCI report from their state of residence. If an offense occurred in another state, a full BCI will also be required from the state in which the offense occurred.

**13. Disciplinary Questions**

Check either Yes or No for each question.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are formal charges pending?
2. Have you ever been denied a Health Professional license, certificate registration or permit in any state?
3. Has an EMS Department/Service, for any reason, ever suspended, restricted, or placed on probation your EMS privilege to practice?

Yes  No

Yes  No

Yes  No

**Note:** If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper.

\_\_\_\_\_  
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**14. National Registration**

Required for EMT and Paramedics ONLY.

Please provide certification information below:

NREMT#:           Expiration Date:

Month Day Year

Exam Date:

Month Day Year

**15. Payment of Fees**

Select appropriate fees and enclose payment as instructed.

**PERSONAL CHECKS ARE NOT ACCEPTED**

**CASHIER'S CHECK OR MONEY ORDERS ONLY.**

- EMT and Cardiac Application Fee . . . . . **\$120.00**
- Examination Fee .(Cardiac Exam Only) . . . . . **\$60.00**
- Re-examination Fee . (Cardiac Re-Exam Only).- . . . . **\$60.00**
- Paramedic Application Fee . . . . . **\$80.00**

Please select these two options only when submitting your initial application for an EMT-Cardiac license.

— Applicable to EMT-Cardiac Applicants Only

**TOTAL ENCLOSED**      \$    **.00**

I am exempt from application/examination fees (see below, must complete Items #10 and #11)

**EXEMPTIONS:** Per Section 23-4.1-10, the following categories of Rhode Island Licensed EMS Providers are considered "Exempt":

- Licensed City or town services, vehicles and their employees.
- Licensed Volunteer or not-for-profit services, vehicles and individuals providing services therein.
- Licensed Fire district service, vehicles and individuals providing services therein.

Required fees must accompany the EMT application.

**PERSONAL CHECKS ARE NOT ACCEPTED**

Fees must be made payable to the General Treasurer, State of Rhode Island and must be either a Cashier's Check or Money Order.

**PLEASE NOTE: ALL FEES ARE NON-REFUNDABLE**

**16. Taxpayer Status/Identity Verification**

- I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all all taxed owed.
- I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the tax administrator.
- I am currently pursuing administrative review of taxes owed to the state.
- I am in federal bankruptcy. (Case # \_\_\_\_\_)
- I am in state receivership. (Case # \_\_\_\_\_)
- I have been discharged from bankruptcy. (Case # \_\_\_\_\_)

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (RIGL 5-76) except as noted. In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number, or Federal Tax Identification Number (for businesses) as appropriate. These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a license.

**17. Affidavit of Applicant**

Complete this section and sign.

I, \_\_\_\_\_, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a Emergency Medical Technician in the State of Rhode Island.

I understand that my records are protected under the Federal and State Regulations governing Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the law. I understand that my records are protected under the Federal and State Laws and Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Division of Emergency Medical Services of any change in the answers to these questions after this application and this affidavit is signed.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date of Signature (MM/DD/YY)



Substitute forms are not acceptable - Copy this form as needed.

# Rhode Island Division of Emergency Medical Services

Room 103, 3 Capitol Hill  
Providence, RI 02908-5097  
(401) 222-2401

## INTERSTATE VERIFICATION FORM - ORIGINAL AND ALL OTHER STATES OF LICENSURE

**Applicant Instructions:** Complete the top portion of this form and forward it to each state or territory where you have been trained and/or licensed, certified or registered as an Emergency Medical Services provider (make copies as necessary).

I am applying for a license to practice as an Emergency Medical Technician in the State of Rhode Island. The Rhode Island Division of Emergency Medical Services requires that the following form be completed by the jurisdiction in which I obtained my original training and/or license and all other states of licensure. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Division of Emergency Medical Services at the above address.

Print/Type Full Name	Signature	Date
Previous Names Used	Social Security Number	Date of Birth
Address	City	State
		Zipcode
Contact Phone Number and Email address	License Number	Date Issued

### THIS SECTION TO BE COMPLETED BY THE EMS LICENSING AGENCY

EMT Program Completed:	Location:	Graduation Date:
Licensed by Examination? <input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant has completed and passed both Written & Practical Exam: <input type="checkbox"/> Yes <input type="checkbox"/> No	
License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed	Original Date Issued:	Expiration Date:

- Questions:**
- Has this licensee ever been investigated by your office?  Yes  No
  - Has this licensee incurred any disciplinary proceedings in your state, or is any action pending?  Yes  No
  - Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation?  Yes  No
  - Do you know of any information that may discredit this person?  Yes  No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Agency order, complaint, etc.).

- Does this certification include use of: 1. Anti-shock Trousers (MAST)?  Yes  No 2. Esophageal Obturator Airway?  Yes  No
- Has this applicant completed course final exam or state practical exam to include the following practical skills: Airway Management, Traction Splint, Kendrick Extrication Device (KED) or Short Board, Long Spine Board, MAST, Patient Assessment?  Yes  No

Certification issued based on:  Completion of a course in compliance with the U.S. Department of Transportation EMT National Standard Curriculum

Reciprocity from the State of \_\_\_\_\_

Reciprocity from the National Registry of Emergency Medical Technicians

Location of Course (Include printout of initial EMT course): \_\_\_\_\_ Date that Certificate was issued: \_\_\_\_\_

### Certification:

Signature	Date	Please Affix Board Seal Here
Type or Print Name	Title	

Full Name of Licensing Agency