(IT IS THE APPLICANT'S RESPONSIBILITY TO MAIL THIS FORM TO THE APPROPRIATE AGENCY)

SNHD
Southern Nevada Health District

REQUEST FOR VERIFICATION OF CERTIFICATION

Authorization to release information to the Southern Nevada Health District Office of EMS & Trauma System (Please print)

Name: _____ Also known as: _____
(Last name, First name, MI)

Social Security Number: _____ Date of Birth: _____

Mailing address: _____ Phone #: _____
(Street, City, State, Zip)

_____ _____
Signature of Applicant **Date signed**

THIS PORTION MUST BE COMPLETED BY THE STATE EMS LICENSING AUTHORITY

Status of Certification/Licensure	**NHTSA National EMS Education Standards**	**National SOP Model**
Certification / License #: _____	☐ EMT	☐ Emergency Medical Technician (EMT)
	☐ Advanced EMT	☐ Advanced EMT (AEMT)
Expiration Date: _____	☐ Paramedic	☐ Paramedic
Status: _____		

HAS YOUR STATE TAKEN ANY DISCIPLINARY ACTION AGAINST THIS PERSON RESULTING IN A SUSPENSION, PROBATION, REVOCATION OR DENIAL FOR EMS CERTIFICATION OR LICENSURE? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE (USE BACK OF FORM, IF NEEDED):

_____

_____

_____

_____

IS THIS INDIVIDUAL CURRENTLY UNDER INVESTIGATION BY YOUR AGENCY? ☐ YES ☐ NO

IF YES, UPON COMPLETION OF INVESTIGATION, PLEASE NOTIFY THE SOUTHERN NEVADA OFFICE OF EMS & TRAUMA OF THE OUTCOME AND ANY DISCIPLINARY ACTION.

DO YOU KNOW OF ANY REASON RECIPROCITY SHOULD BE DENIED? ☐ YES ☐ NO

IF YES, WHY? _____

_____

_____

I hereby certify that the above information is true and correct as recorded by this office.

_____ _____ _____
Signature Name (print) Date

_____ _____
Title Agency Name

Please fax, email or mail the completed form to: Southern Nevada Health District
Office of EMS & Trauma System
P.O. Box 3902
Las Vegas, NV 89127

Phone: 702-759-1050
Fax: 702-759-1413
Email: ems@snhd.org