



REQUEST FOR VERIFICATION OF CERTIFICATION

Sections 1 & 2 below must be completed by the applicant and sent to any state(s) where an EMS certificate or license has ever been issued. Please note that some states may charge a fee to complete this form. **(IT IS THE APPLICANT'S RESPONSIBILITY TO MAIL THIS FORM)**

Section 1: Authorization to release information to Southern Nevada Health District Office of EMS & Trauma System

Name: _____
(Last name, First name, MI)

Also known as: _____

Mailing address: _____
(Address, City, State, Zip)

Section 2: Applicant's consent

I hereby authorize the (state in which you are currently certified/licensed) _____
EMS agency to furnish the information requested in Section 3 below:

Certification/License #: _____ EMS Level/type: _____

Issue Date: _____ Expiration Date: _____

Social Security Number: _____ Date of birth: _____
(mm/dd/yyyy)

Section 3: This section to be completed by the State Certification or Licensure Authority

Status of EMS certification/license: Inactive Active

EMS level/type of certification: _____

Reciprocity granted on certification from: _____
(State, national registry)

(see back page)

- Is the above certificate approved and valid in your office? Yes No
- Has the above certificate been revoked or suspended? Yes No
- Has the above applicant ever had a license, medical direction/
control or clinical privileges revoked or suspended? Yes No
- Is the above applicant currently under any investigation
or review to the best of your knowledge? Yes No
- Do you know of any reason reciprocity should be denied? Yes No

If yes, why? _____

I hereby certify that the above is true and correct as recorded in the files of this office.

Signature Name (print)

Title Date

State Certification/Licensing Agency(s):

Please complete Section 3 of this form and return it to:

Office of EMS & Trauma System
Southern Nevada Health District
P.O. Box 3902
Las Vegas, NV 89127
Phone: 702-759-1050
Fax: 702-759-1413