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

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):

____

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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