



# Mountain-Valley

Emergency Medical Services Agency

## EMT-P Accreditation Application

(Check One): Accreditation \_\_\_\_\_ - \$75.00    Information Update \_\_\_\_\_ (No Fee if submitted prior to expiration date)

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_    DL #: \_\_\_\_\_    DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME TELEPHONE #: (    ) \_\_\_\_\_ CELL #: (    ) \_\_\_\_\_

PAGER #(    ) \_\_\_\_\_ EMAIL: \_\_\_\_\_

PRIMARY EMPLOYER: \_\_\_\_\_ POSITION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE #: (    ) \_\_\_\_\_

CITY/STATE: \_\_\_\_\_ FAX #: (    ) \_\_\_\_\_

CA EMT-P LICENSE NUMBER: \_\_\_\_\_ EXPIRATION DATE: \_\_\_\_\_ (attach copy of card)

*(This Section for Initial Accreditation Only) / (Circle Yes or No)*

8 hr. MVEMSA-MCI Training Completed: YES / NO    MVEMSA EMT-P Orientation Attended: YES / NO

8 hr. MVEMSA-Trauma Training Completed: YES / NO

*Optional Scope Training Completed:*

Pedi Oral Intubation: YES / NO    Adult NTI: YES / NO    Intraosseous Access: YES / NO

APPLICANT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

### FOR OFFICE USE ONLY:

AUTH #: \_\_\_\_\_ CO.: \_\_\_\_\_ DATE: \_\_\_\_\_ EXP: \_\_\_\_\_

database: \_\_\_\_\_ card mailed: \_\_\_\_\_ letter mailed: \_\_\_\_\_ amount paid: \_\_\_\_\_

***\*\*Submit application early to allow for the TEN (10) day processing Time!\*\****

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