

APPLICATION FOR FIRST RESPONDER RECERTIFICATION

SSN#: _____

LAST NAME: _____ FIRST NAME: _____

EMPLOYER: _____ POSITION: _____

ADDRESS: _____ PHONE #:() _____

CITY/STATE: _____ FAX #: () _____

HOME MAILING ADDRESS: _____

CITY: _____ ZIP _____

HOME TELEPHONE #:() _____ CELL PHONE #:() _____

PAGER #:() _____ EMAIL: _____

DRIVERS LICENSE #: _____ DOB: ____/____/____

CURRENT CERTIFICATION NUMBER: _____ EXPIRATION DATE: _____ (attach copy of card)

CERTIFYING AGENCY: _____

CPR CERTIFYING ORGANIZATION: _____ EXPIRATION DATE: _____ (attach copy of card)

Have you ever had any action taken against your certification, such as being suspended or revoked for any reason, or have you ever been denied certification?

Q Yes Q No If yes, thoroughly explain on a separate piece of paper and attach to this application.

FOR OFFICE USE ONLY: CERT #: _____ CO.: _____ DATE: _____ EXP: _____

TEST DATE: _____ SCORE: _____ RETEST BY: _____ Paid: _____ Date: _____ Check#: _____

Signatures CPR ID Fee Late fee Written test Skills test

database: _____ card sent: _____ letter sent: _____

Please read the following Section of the Health and Safety Code and Statements 1-4. If any portion applies to you, you may not be eligible for certification.

1798.200 (a) The medical director of the local EMS agency may place on probation any certificate holder or suspend, deny or revoke any First Responder, EMT-I, or EMT-II certificate or suspend or recommend to the authority the revocation of any EMT-P certificate issued under this division, in accordance with guidelines established by the authority, upon the finding by that medical director of an imminent threat to the public health and safety as evidenced by the occurrence of any of the following actions:

- (1) Fraud in the procurement of any certification under this division.
- (2) Gross negligence.
- (3) Repeated negligent acts.
- (4) Incompetence.
- (5) The commission of any fraudulent, dishonest, or corrupt act which is substantially related to the qualification, functions, and duties of prehospital personnel.
- (6) Conviction of any crime which is substantially related to the qualifications, functions, and duties of prehospital personnel. The record of conviction or certified copy of the record shall be conclusive evidence of such conviction.
- (7) Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this division or the regulations promulgated by the authority pertaining to prehospital personnel.
- (8) Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances.
- (9) Addiction to the excessive use of, or the misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.
- (10) Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by any other license or certification.
- (11) Demonstration of irrational behavior or occurrence of a physical disability to the extent that a reasonable and prudent person would have reasonable cause to believe that the ability to perform the duties normally expected may be impaired.

1. I am not required to register as a sex offender under the provisions of Section 290 of the Penal Code.
2. I have not at any time during the preceding seven (7) years been convicted of any offense relating to the use, sale, possession, or transportation of narcotics, addictive or dangerous drugs.
3. I have never been convicted of any offense punishable as a felony involving force, violence, threat or intimidation, or been convicted of theft in either degree, or committed any act involving moral turpitude including fraud or intentional dishonesty during the preceding seven (7) years.
4. I have never been convicted of any crime other than a traffic violation.

I have read and understand Section 1798.200 of the Health and Safety code (above) and statements 1 - 4. I am not precluded from being certified for any reason defined in Section 1798.200 or statements 1-4, or I have enclosed a complete explanation of any item that applies to me. I am eighteen (18) years of age or older. I hereby certify that all information on this application is true and correct to the best of my knowledge and belief, and I understand that any falsification or omission of material facts may cause forfeiture on my part of all rights to First Responder certification in the State of California. I understand all information on this application is subject to verification and I hereby give my express permission for the Mountain-Valley EMS Agency to contact any employer or agency for information related to my role and function as a First Responder in California.

SIGNATURE: _____

DATE: _____

PRINTED NAME: _____

Remember to include your \$30.00 application fee payable to the EMS Agency, copies of your CPR certification card and a picture identification with your application.

C:\Documents and Settings\scott.MVEMSA.000\Local Settings\Temp\FIRST RESPONDER RECERTIFICATION.wpd



See back of form for instructions for completion

1a. Name as shown on EMT-I Certificate	1b. Certificate Number	1c. Signature
1d. Certifying Authority	1e. Date	I certify, under the penalty of perjury, that the information contained on this form is accurate.
Skill	Verification of Competency	
1. Patient examination, trauma patient;	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
2. Patient examination, medical patient	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
3. Airway emergencies	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
4. Breathing emergencies	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
5. Automated external defibrillation	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
6. Circulation emergencies	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
7. Neurological emergencies	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
8. Soft tissue injury	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
9. Musculoskeletal injury	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
10. Obstetrical emergencies	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number

INSTRUCTIONS FOR COMPLETION OF EMT-I SKILLS COMPETENCY VERIFICATION FORM

A completed EMT-I Skills Verification Form is required to accompany an EMT-I recertification application for those individuals who are either maintaining EMT-I certification without a lapse or to renew EMT-I certification with a lapse in certification less than one year.

1a. Name of Certificate Holder

Provide the complete name, last name first, of the EMT-I certificate holder who is demonstrating skills competency.

1b. Certificate Number

Provide the EMT-I certification number from the current or lapsed EMT-I certificate of the EMT-I certificate holder who is demonstrating competency.

1c. Signature

Signature of the EMT-I certificate holder who is demonstrating competency. By signing this section the EMT-I is verifying that the information contained on this form is accurate and that the EMT-I certificate holder has demonstrated competency in the skills listed to a qualified individual.

1d. Certifying Authority

Provide the name of the EMT-I certifying authority for which the individual will be certifying through.

Verification of Competency

1. Affiliation - Provide the name of the training program or EMS service provider that the qualified individual who is verifying competency is affiliated with.
2. Once competency has been demonstrated by direct observation of an actual or simulated patient contact, i.e. skills station, the individual verifying competency shall sign the EMT-I Skills Competency Verification Form (EMSA-SCV 07/03) for that skill.
3. Qualified individuals who verify skills competency shall be currently licensed or certified as: An EMT-I, EMT-II, Paramedic, Registered Nurse, Physician Assistant, or Physician and shall be either a qualified instructor designated by an EMS approved training program (EMT-I training program, paramedic training program or continuing education training program) or by a qualified individual designated by an EMS service provider. EMS service providers include, but are not be limited to, public safety agencies, private ambulance providers, and other EMS providers.
4. Certification or License Number – Provide the certification or license number for the individual verifying competency.
5. Date- Enter the date that the individual demonstrates competency in each skill.
6. Print Name – Print the name of the individual verifying competency in the skill.

Verification of skills competency shall be valid to apply for EMT-I recertification for a maximum of two years from the date of verification.