

Joe Lombardo  
Governor



Richard Whitley, MS  
Director

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH  
*Helping people. It's who we are and what we do.*



Cody Phinney  
Administrator

Ihsan Azzam,  
Ph.D., M.D.  
Chief Medical Officer

## **VERIFICATION OF EMS LICENSE/CERTIFICATION FORM**

**Applicant-** Complete the top portion of this form and forward it to each state or territory (not applicable to the National Registry) where you have been licensed, certified, or registered as an emergency medical services provider (make copies as necessary).

### **Section 1: Applicant information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Original License/Certification number \_\_\_\_\_

Date issued: \_\_\_\_\_ (in the state to which the form is being forwarded)

Type:  Emergency Medical Technician  Advanced Emergency Medical Technician  Paramedic

Signature \_\_\_\_\_ Date: \_\_\_\_\_

### **TO BE COMPLETED BY VERIFYING AGENCY ONLY**

**Section 2: Verifying Organization:** Please complete this section as fully as possible. The information you provide determine this individual's eligibility for Nevada EMS certification.

I certify that the above-named individual was issued license/certificate number: \_\_\_\_\_

License/Certificate Level: \_\_\_\_\_ Issued Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Does your agency currently require successful completion of a training program adhering to the United States Department of Transportation, National Highway Traffic Safety Administration National Standard Curriculum? YES NO. If no, please provide a brief description of the requirements this individual completed for purposes of certification. (Separate document)

Has this individual ever been subject to disciplinary action of any type or is this individual currently the subject of a pending disciplinary action or unresolved complaint? YES NO.

If yes, please forward all publicly disclosable information regarding the individual's status and the basis for same.

Has the applicant been subject to a background check in your state? YES NO

If yes, date of last background check: \_\_\_\_\_

Please provide the criteria utilized to conduct the applicants background check: \_\_\_\_\_

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Title: \_\_\_\_\_ Name of Agency: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Completed forms can be sent to the Nevada EMS Program by email: [HealthEMS@health.nv.gov](mailto:HealthEMS@health.nv.gov) or fax: (775) 687-7595.

Verifying State
Seal