

Amt Rec'd: _____

Check/MO: _____

Receipt No.: _____

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
EMERGENCY MEDICAL SYSTEMS

NV EMS #: _____

AMBULANCE AND FIRE AGENCY ATTENDANT APPLICATION

This application must be completed and submitted to the Division of Public and Behavioral Health EMS. Please indicate below if this is an initial, a renewal or an upgrade from Driver Only to Attendant and include the documentation requested for that process.

Initial Attendant Application

- A. A check or money order for \$10.00** made payable to: Division of Public and Behavioral Health EMS.
 - B. If in the last 6 months you were a resident of a state other than Nevada, submit a current driving record provided by the Department of Motor Vehicles of that state.
 - C. One of the following:
 - a. Two full sets of fingerprints and a check or money order in the amount of \$36.25** made payable to: Division of Public and Behavioral Health EMS.
 - OR
 - b. Proof of having completed the LiveScan fingerprint process and a check or money order in the amount of \$36.25** made payable to: Division of Public and Behavioral Health EMS.
- (Complete details about the LiveScan process are on page 4 of this application)**

Renewal Attendant Application

- A. A check or money order for \$5.00** made payable to: Division of Public and Behavioral Health EMS.
- B. If you are a resident of a contiguous state (i.e.: Utah, California, Idaho, Oregon, Arizona) and are working in Nevada, provide a current driving record provided by the Department of Motor Vehicles of that state

Upgrade from Driver Only to Attendant

- A. A check or money order for \$5.00** made payable to: Division of Public and Behavioral Health EMS.
- B. If you are a resident of a contiguous state (i.e.: Utah, California, Idaho, Oregon, Arizona) and are working in Nevada, provide a current driving record provided by the Department of Motor Vehicles of that state.

Name: _____
(Last) (First) (Middle)

Address: _____
(Street/P.O. Box) (City) (State) (Zip)

Phone: _____ / _____ / _____ Email Address: _____
(Work) (Cell) (Home)

Type of Attendant: Volunteer Paid Air

Name of Service you intend to be associated with: _____ Permit # _____

Military Veteran Information: Yes: No:

Branch of Service: _____ Length of Service: _____

1. PERSONAL INFORMATION:

S.S. #: _____ D.L. #: _____ State of Issue: _____

Date of Birth: _____ Male Female

6. SKILLS REVIEW

All applicants must provide proof of skills retention at the Basic level. In addition, Advanced EMTs and Paramedics must provide proof of skills retention at their respective levels.

Skill evaluators must be a state qualified instructor, RN, PA or physician.

Basic Skills – To be completed by all applicants

Skill	Date	Pass	Fail	Print Evaluator's Name	Evaluator's Signature (Sign in BLUE ink)
Mouth to Mask					
Airway Maintenance					
Oxygen Administration					
(Semi) Automatic External Defibrillator					
Patient Assessment					
Bleeding Control / Shock Management					
Immobilization (Bone, Joint, Traction)					
Spinal Immobilization					

Intermediate Skills – To be completed by all Advanced EMTs

Skill	Date	Pass	Fail	Print Evaluator's Name	Evaluator's Signature (Sign in BLUE ink)
Endotracheal (Primary)					
Supra-glottic (Secondary)					
I.V.					
Intra Ossous Infusion					
Medication Administration					

Advanced Skills - To be completed by all Paramedics

Skill	Date	Pass	Fail	Print Evaluator's Name	Evaluator's Signature (Sign in BLUE ink)
1.Ventilatory Management					
2.Cardiac Arrest Management					
3.Cardiac Dysarrhythmia Management					
4.Intravenous Infusion					
5.Intraosseous Infusion					
6.Medication Administration					
7.Chest Decompression					
8.NG Tube					

The above-named person.

- Has been found competent in the administration of these skills to my satisfaction and is recommended to be relicensed at the level of care currently held by the applicant.
- Has **not** been found competent in the administration of these skills to my satisfaction and is **not** recommended to be relicensed.

Printed name of EMS Coordinator / Director

Signature of EMS Coordinator / Director

ALL APPLICANTS MUST COMPLETE THIS FINAL PAGE

7. BACKGROUND CHECK

If you are submitting via LiveScan electronic fingerprint system, you will need to provide our acct #, our ORI and our appropriate NRS citation to the LiveScan operator. They are as follows:

Account #	880485
ORI	NV0131700
Reason Fingerprinted	NRS 450B.800

Please insure the LiveScan operator does not enter their department identifier in the ORI field. The results will not be available to our office.

If your LiveScan submission is completed by Law Enforcement, please have the following statement completed:

I hereby certify that I have completed the LiveScan electronic fingerprint process for the applicant using the account information provided in this document.

Printed Name of Law Enforcement Official Submitting via LiveScan: _____

Signature of Law Enforcement Official Submitting via LiveScan: _____ Date: _____
Signature (Sign in BLUE ink)

****Please be aware that when the LiveScan system is used the Nevada Division of Public and Behavioral Health EMS Office will automatically be billed by the Department of Public Safety (DPS). If you have not submitted your application and all applicable fees to our office by the time we receive a bill from DPS we will bill you for the background check fee of \$36.25****

If your LiveScan submission is completed by an outside vendor, please have the following statement completed:

LiveScan completed by an outside vendor:

I hereby certify that I have completed the LiveScan electronic fingerprint process for the applicant using the account information provided in this document. I further certify that the background check fee has been received from the individual being fingerprinted.

Printed Name of Official Submitting via LiveScan: _____

Signature of Official Submitting via LiveScan: _____ Date: _____

If LiveScan is not available in your area, the hard copy fingerprint cards can be submitted.

CERTIFICATION OF APPLICANT: This application **must** be signed and dated (within the last 6 months).

I hereby certify that all statements made in this application are true and I agree and understand that any misstatements of material facts herein may cause forfeiture on my part of all rights to certification and/or licensure by the State of Nevada as an Emergency Medical Technician and/or Ambulance Attendant.

**ANY MISREPRESENTATION OR OMISSION MAY RESULT IN FORFEITURE
OR DENIAL OF CERTIFICATE**

**\$25.00 fee on all returned checks

Signed: _____ Date: _____
Applicant (Sign in BLUE ink)

**DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
EMERGENCY MEDICAL SYSTEMS
4150 Technology Way, Suite 101
Carson City, NV 89706
(775) 687-7590**

- Please indicate here if you **DO NOT** wish to be subscribed to our ListServ to receive information and updates from the Health Division's Office of Emergency Medical Systems. If you leave this box blank we will add you to our ListServ.

(EMS Office Use Only)

Reviewed by: _____ Date: _____ Approve: Deny:

Expiration Date: _____ Cert. Level: _____

Endorsements: EMS Instructor Attendant Aero Attendant

Date Entered in Database: _____ Date Printed: _____