

Amt Rec'd: _____

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Receipt No.: _____

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

NV EMS #: _____

EMERGENCY MEDICAL SERVICES RENEWAL APPLICATION

This renewal application can be used for renewal of both your EMS Certification and your Ambulance Attendant License.

CERTIFICATION ONLY: If you are renewing only your EMS certification please fill out the first two pages of this application, then skip to page 5 and complete the Child Support Statement, sign and date the application and submit with a check or money order for \$10.00** payable to the Division of Public and Behavioral Health EMS.

CERTIFICATION & LICENSE: If you are employed by or a volunteer with a permitted ambulance service please fill out all five pages of this application, sign and date on the last page and submit with a check or money order for \$15.00** payable to the Division of Public and Behavioral Health EMS.

Your application must be accompanied by a current CPR card at the Health Care Provider or equivalent.

If you are a Paramedic, your application must also be accompanied by a current ACLS, PALS, ITLS (or equivalent) Cards.

- | | | | |
|--|--|--|--------------------------------------|
| Level of certification you are applying for: | <input type="checkbox"/> EMR | <input type="checkbox"/> EMD | <input type="checkbox"/> EMT |
| | <input type="checkbox"/> Advanced EMT | <input type="checkbox"/> Paramedic | |
| Certification endorsements you are applying for: | <input type="checkbox"/> EMS Instructor | <input type="checkbox"/> Immunization | |
| | <input type="checkbox"/> Critical Care Paramedic | <input type="checkbox"/> Community Paramedic | |
| Also applying to renew a license as a: | <input type="checkbox"/> Ground attendant | <input type="checkbox"/> Aero Attendant | |
| Type of Attendant: | <input type="checkbox"/> Volunteer | <input type="checkbox"/> Career | <input type="checkbox"/> Driver Only |

Primary Service you are associated with: _____ Permit # _____

Secondary service you are associated with: _____ Permit # _____

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

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

DOB: _____ SS#: _____ Male Female

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

Employment Address: _____
(Street) (City) (State) (Zip)

**RENEWAL OF AMBULANCE ATTENDANT LICENSE
(Not required for renewal of certification only)**

2. DRIVER'S LICENSE INFORMATION:

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

If you are a resident of Nevada, we will attempt to run your driving record for you. 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.

- A. Have you, within the last 5 years, been convicted or forfeited bail for a traffic violation other than a parking violation? Yes No
- B. Have you ever been convicted of a felony or misdemeanor other than a traffic violation? Yes No
- C. Have you ever been licensed as a driver, attendant, attendant-driver or air attendant? Yes No
- D. Have you ever had an attendant license or EMS certificate revoked or suspended in Any jurisdiction? Yes No

If your answer to question 2.A. or 2.B. is "YES", explain fully below:

Date	City/State	Violation Give exact nature of all violations	Fine or Disposition of case

If your answer to 2.C. or 2.D. is "YES", explain in full below (attach a separate sheet as necessary):

3. PHYSICIANS STATEMENT: (must be dated within last 6 months, may be conducted by PA or NP)

_____ is of sound physical and mental health and is free of physical defects or diseases which might impair his/her ability to drive or attend an ambulance, air ambulance, or agency vehicle.

Physicians Signature (Sign in **BLUE** ink) _____ Date _____ License Number

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

4. SERVICE REVIEW:

I have reviewed this application and I approve of the applicant being issued an ambulance attendant license by the Division of Public and Behavioral Health EMS.

Service EMS Coordinator: _____ **Date:** _____
Signature (Sign in **BLUE** ink)

Service Medical Director: _____ **Date:** _____
Signature (Sign in **BLUE** ink)

5. 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 or the service Medical Director.

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 (Sign in **BLUE** ink)

ALL APPLICANTS MUST COMPLETE THIS FINAL PAGE

6. CHILD SUPPORT INFORMATION: (Certificate and/or License **will not** be issued unless the applicant provides the following information.)

Please check one of the following:

- I am not subject to a court order for the support of a child.
- I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the District Attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or
- I am subject to a court order for the support of one or more children and am not in compliance with the order or a plan approved by the District Attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

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 for 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 Immunization Critical Care Paramedic
 Attendant Aero Attendant Community Paramedic

Date Entered in Database: _____ Date Printed: _____