

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

APPLICATION FOR COMMUNITY PARAMEDICINE PROVIDER ENDORSEMENT

INSTRUCTIONS: Please type this form and fill out completely. This form must be mailed to the Division of Public and Behavioral Health, 4150 Technology Way, Suite 101, Carson City, NV 89706.

1. Name: _____

Mail Address: _____
Street/PO Box City Zip

Home Phone or Cell Phone: _____ Work Phone: _____
(Circle One)

2. Nevada EMS #: _____

3. Current Level of Certification: EMT AEMT Paramedic

4. Name of Agency you will be associated with: _____ Permit #: _____

5. Agency Coordinator Name: _____
Last First Middle

6. EDUCATION REQUIREMENTS: Please attach a copy of a completed Paramedic Accredited Program certificate or an EMT/AEMT State Approved community paramedic training program certificate.

7. Paramedic National Practitioner Identification #: _____

8. CHILD SUPPORT INFORMATION: Certificate cannot 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.

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

9. CERTIFICATION OF APPLICANT: **This application must be signed and dated.**

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 by the State of Nevada as an Emergency Medical Technician.

10. Applicant Signature: _____
Sign in BLUE ink Date

(EMS Office Use Only)			
Regional Office Reviewed by: _____	Date: _____	Approve: <input type="checkbox"/>	Deny: <input type="checkbox"/>
Education Coordinator Reviewed by: _____	Date: _____	Approve: <input type="checkbox"/>	Deny: <input type="checkbox"/>