

# STATE VERIFICATION

OF EMERGENCY MEDICAL SERVICES  
 LICENSURE AND/OR CERTIFICATION

**TO BE COMPLETED BY THE APPLICANT**, THEN SEND TO EACH STATE AGENCY IN WHICH YOU HAVE HELD CERTIFICATION  
**PRINT LEGIBLY IN BLACK OR BLUE INK – ALL FIELDS REQUIRED**

<b>NAME:</b>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
	<small>FIRST</small>	<small>MIDDLE</small>	<small>LAST</small>
<b>SOCIAL SECURITY NUMBER:</b>	<input style="width: 95%;" type="text"/>	<b>DATE OF BIRTH (mm/dd/yyyy):</b>	<input style="width: 95%;" type="text"/>
<b>STATE OF CERTIFICATION/LICENSURE:</b>	<input style="width: 95%;" type="text"/>	<b>CERTIFICATION/LICENSURE#:</b>	<input style="width: 95%;" type="text"/>
<b>NUMBER OF STATES IN WHICH YOU HAVE HELD EMT CERTIFICATION/LICENSURE</b> (VERIFICATION FORMS REQUIRED FROM EACH):	<input style="width: 95%;" type="text"/>		

**BELOW TO BE COMPLETED BY THE STATE EMS OFFICE**

The above named individual is applying for Massachusetts EMT certification and reported holding **current and/or prior** credentials from your agency. Please complete the following information regarding all current and/or prior certifications which your agency has issued a credential for and **return it directly to our office**. Please call 617-753-7300 with any questions or concerns.

	CERTIFICATION NUMBER	ISSUE DATE	EXPIRATION DATE	NOTES / COMMENTS
EMT/EMT-BASIC				
EMT-I 85/99				
ADVANCED EMT				
PARAMEDIC/EMT-PARAMEDIC				
Other: _____				

<p><b>Is this applicant's certification/license in good standing?</b>                  (No compliance issues on the record and no pending compliance issues)</p> <p><input type="checkbox"/> YES  <input type="checkbox"/> NO (please attach documentation of the incident)</p>	<p><b>Has this applicant's certification/license ever been suspended and/or revoked in your state?</b></p> <p><input type="checkbox"/> YES (please attach documentation of the incident)  <input type="checkbox"/> NO</p>
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INDIVIDUAL VERIFYING ( <b>PRINT</b> )	TITLE
INDIVIDUAL VERIFYING ( <b>SIGNATURE</b> )	DATE
LICENSING AGENCY	PHONE NUMBER

<b>PLEASE RETURN THIS DOCUMENT DIRECTLY TO MASSACHUSETTS OEMS BY EITHER FAX OR MAIL</b>	
FAX: <b>617-753-7320</b> ATTN: EMS CERTIFICATION VERIFICATION	<b>MASSACHUSETTS DPH-OEMS</b> ATTN: CERTIFICATION (VERIFICATION) 99 CHAUNCY STREET (11 <sup>TH</sup> FLOOR) BOSTON MASSACHUSETTS 02111