



# Rhode Island Department of Health Center for Emergency Medical Services

3 Capitol Hill , Room 105  
Providence, RI 02908-5097

*Application For*

## ***License as an Emergency Medical Services Practitioner***

Select the level of EMS license you are applying for (check one):

- EMR**    
  **EMT**    
  **AEMT**    
  **Advanced EMT-Cardiac (AEMT-C)**    
  **Paramedic**

### MILITARY STATUS ELIGIBILITY

*(Documentation Required)  
see last page for instructions*

Please check ONE of the following criteria for expedited application:

- I am in active military duty or a reservist  
 I am a military veteran with honorable discharge  
 I am the spouse of someone in active military duty or the spouse of a reservist

*Applicant - Print Name*

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*LAST NAME*

*FIRST NAME*

*MI*

**\*Do Not Hand Deliver - Application Must Be Mailed\***

FOR DEPARTMENT OF HEALTH USE ONLY

<input type="checkbox"/> Approved	<input type="checkbox"/> Denied	Date _____	By _____
EMT# _____		Expiration Date: _____	

Phone: (401) 222-2401

TTY/TDD: (800) 745-5555

Fax: (401) 222-3352

# GENERAL INFORMATION

1. Requirements for EMS practitioner licensure are established by the Rules and Regulations 216-RICR-20-10.2 available through the Center for EMS website at <http://www.health.ri.gov/licenses>
2. EMT licensure can be denied pursuant to the provisions of the Rules and Regulations 216-RICR-20-10.2. Statements or documents may be considered sufficient cause to deny or revoke a license as an EMS practitioner in Rhode Island and may result in additional penalties as determined by law. The Department may conduct random application audits, requiring the EMS practitioner applicant to file proof of completion of the above training requirements for renewal.
3. Should you have any questions regarding the EMS practitioner license requirements or completion of the application form, contact (401) 222-2401.
4. Please allow 4-6 weeks for applications to be processed. You can visit our website at <http://www.health.ri.gov> and click on Verify a License in order to check on the status of your application.



**PLEASE NOTE: This application form (dated 02/08/2019) supplants all previous versions. Prior versions of the application will not be accepted or processed.**

## APPLICATION INSTRUCTIONS

1. Complete all application materials as instructed. Please answer all questions. Incomplete questions or incomplete applications will not be processed. Please mark "NA" on questions that are Not Applicable.
2. Do not detach any full pages from this booklet.
3. Please type this application using the fillable form online then print the completed application.
4. Sign the application and return it with the required fee(s).  
  
Do not submit the application without all applicable information, documentation and fee(s).
5. Mail the completed application to: (Do Not Hand Deliver)  
Rhode Island Department of Health  
Division of Emergency Medical Services  
Room 104, 3 Capitol Hill  
Providence RI 02908-5097  
  
Please note: Extra postage will be required.
6. **Faxed applications WILL NOT be accepted.**

**PERSONAL CHECKS WILL NOT BE ACCEPTED.  
PAYMENT MUST BE A (CASHIER'S CHECK OR MONEY ORDER)**

## REQUIRED DOCUMENTATION

1. **ALL** applicants at any level must submit an **ORIGINAL** Bureau of Criminal Identification (BCI) report. You must apply to the Department of Attorney General's Office. For information on this process please visit: <http://www.riag.state.ri.us/homeboxes/BackgroundChecks.php>. Out-of-state applicants should check with the Attorney General's office from their state of residence.
2. Photostatic copy (front and back) of a **current - signed** Healthcare Provider level or equivalent cardiopulmonary resuscitation (CPR) card eg. (American Heart Association Healthcare Provider, American Red Cross Professional Rescuer, American Safety and Health Institute CPRPRO, Medic First Aid BLSPRO, or National Safety Council Professional Rescuer CPR). **This card must be signed.**
3. **For First-Time Applicants** - photostatic copy of High School Diploma or GED
4. Photostatic copy of diploma or certificate from the licensed EMS training provider verifying completion of the EMT training program specific to the level of licensure application.
5. **EMR, EMT, AEMT and Paramedic Applicants** - photostatic copy of current NREMT Registration  
  
**In Addition to 1-6 Out of State AEMT Applicants Must Also Complete 6-8**
6. Photostatic copy of EMS Practitioner license from a state other than Rhode Island, if applicable.
7. Photostatic copy of current registration with the National Registry of Emergency Medical Technicians if applying for EMR, EMT, AEMT or Paramedic.
8. Interstate Verification Form completed by each state (other than Rhode Island) in which the applicant has been licensed.

**IMPORTANT: Licensure is an individual responsibility and NOT the responsibility of your employer or supervisor.**



State of Rhode Island
Center for Emergency Medical Services
Application for License as an Emergency Medical Technician

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your license and reported to those who inquire about your license. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., etc.)
First Name
Middle Name
Surname, (Last Name)
Suffix (i.e., Jr., Sr., II, III)
Maiden, if applicable
Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Division of Taxation to verify that no taxes are owed to the State.

3. Gender

Please select from the dropdown.

4. Date of Birth

Month Day Year

5. Home Address

It is your responsibility to notify the EMS Office of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)
Second Line Address (Number and Street)
City State Zip Code
Country, If NOT U.S.
Home Phone Home Fax
Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Rhode Island License

Please provide information concerning your previous licensure in the State of Rhode Island, if applicable.

Have you ever been licensed as an EMT in Rhode Island? Yes No

If the answer to this question is "yes", provide license number, and if applicable, enter all other state abbreviation(s) of EMT licenses you hold or may have held in Question 7.

Rhode Island License Number E M T License Number

**7. Other State Licensure**

List all states or countries in which you are now or ever have been licensed to practice as an EMT.

**YOU must send a copy of the Interstate Verification Form to each entity (see page 10).**

State/Country:	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	State/Country:	_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive
_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive		_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	
_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive		_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	
_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive		_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	
_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive		_____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive	

**8. Program Information**

_____ Name of Program Director																			
_____ Name of Medical Director																			
_____ License Number of Instructor-Coordinator																			
_____ EMS Training Institution																			
_____ Month			_____ Day			_____ Year				_____ Month			_____ Day			_____ Year			

**9. Disaster Availability**

I am interested in becoming a volunteer emergency responder during a disaster or state of emergency.  Yes  No

**10. Rhode Island Ambulance Service Affiliation**

Please list only ONE affiliation. If you have no affiliation, please mark question as NA.

_____ Licensed Ambulance Service																																							
_____ 1st Line Address (Department/Suite/Room Number, etc.)																																							
_____ Second Line Address (Number and Street)																																							
_____ City										_____ State										_____ Zip Code																			
_____ Country, if NOT U.S.																				_____ Postal Code, if NOT U.S.																			
_____ Business Phone			_____ Extension			_____ Business Fax				_____ Extension			_____ Business Fax				_____ Extension			_____ Business Fax																			

**11. Licensed Ambulance Service Verification**

To be completed by Chief of department or service.

I hereby certify that \_\_\_\_\_ is a bonafide member of my EMS Service/Department and that said affiliation is true and accurate.

\_\_\_\_\_  
Printed Name of Chief

\_\_\_\_\_  
Signature of Chief

\_\_\_\_\_  
Date of Signature

**12. Active Military or Veteran**

Are you or your spouse a veteran or active military?

- Yes, I am a veteran or active military
- Yes, my spouse is a veteran or active military
- No, neither I nor my spouse would be considered veterans or active military

If applying for expedited military status, please complete the Military Expedition Form at the end of this application packet.

**13. Criminal Convictions**

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, pleaded *Nolo Contendere*, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance, or are any formal charges pending?

Yes  No

Abbreviation of State and Conviction<sup>1</sup> (e.g. CA - Illegal Possession of a Controlled Substance):

	Month	Year
_____	<input type="text"/>	<input type="text"/>
_____	<input type="text"/>	<input type="text"/>
_____	<input type="text"/>	<input type="text"/>

**14. Disciplinary Questions**

Check either Yes or No for each question.

1. Has any health professional license, certificate, registration, or permit you hold or have held, been disciplined or are formal charges pending?
2. Have you ever been denied a health professional license, certificate registration or permit in any state?
3. Has an Ambulance Service, for any reason, ever suspended, restricted, or placed on probation your EMS privilege to practice?

Yes  No

Yes  No

Yes  No

**Note:** If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper.

15. National Registration

Please provide certification information below:

NREMT#: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] Expiration Date: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
Month Day Year

Exam Date: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
Month Day Year

16. Payment of Fees

Select appropriate fees and enclose payment as instructed.

PERSONAL CHECKS ARE NOT ACCEPTED

CASHIER'S CHECK OR MONEY ORDERS ONLY.

[ ] EMT and AEMT-C Application Fee . . . . . \$120.00

[ ] EMR, AEMT, and Paramedic Application Fee . . . . . \$80.00

TOTAL ENCLOSED \$ [ ] [ ] [ ] .00

[ ] I am exempt from application fees (see below, must complete Items #10 and #11)

EXEMPTIONS: Per Rhode Island General Law 23-4.1-10 the following categories of Rhode Island Licensed EMS Providers are considered "exempt":

- Licensed city or town services, vehicles and their employees.
• Licensed volunteer or not-for-profit services, vehicles and individuals providing services therein.
• Licensed fire district service, vehicles and individuals providing services therein.

Required fees must accompany the application.

PERSONAL CHECKS ARE NOT ACCEPTED

Fees must be made payable to the General Treasurer, State of Rhode Island and must be either a Cashier's Check or Money Order.

PLEASE NOTE: ALL FEES ARE NON-REFUNDABLE

17. Affidavit of Applicant

Complete this section and sign.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a Emergency Medical Technician in the State of Rhode Island.

I understand that my records are protected under the Federal and State Regulations governing Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the law. I understand that my records are protected under the Federal and State Laws and Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Center for Emergency Medical Services of any change in the answers to these questions after this application and this affidavit is signed.

Signature of Applicant \_\_\_\_\_

Date of Signature (MM/DD/YY) \_\_\_\_\_



Substitute forms are not acceptable - Copy this form as needed.

### Center for Emergency Medical Services

Room 104, 3 Capitol Hill  
Providence, RI 02908-5097  
(401) 222-2401

## INTERSTATE VERIFICATION FORM - ORIGINAL AND ALL OTHER STATES OF LICENSURE

**Applicant Instructions:** Complete the top portion of this form and forward it to each state or territory where you have been trained and/or licensed, certified or registered as an Emergency Medical Services provider (make copies as necessary).

I am applying for a license to practice as an Emergency Medical Services Practitioner in the State of Rhode Island. The Rhode Island Center for Emergency Medical Services requires that the following form be completed by the jurisdiction in which I obtained my original training and/or license and all other states of licensure. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Division of Emergency Medical Services at the above address.

Print/Type Full Name	Signature	Date
Previous Names Used	Social Security Number	Date of Birth
Address	City	State Zipcode
Contact Phone Number and Email address	License Number	Date Issued

### THIS SECTION TO BE COMPLETED BY THE EMS LICENSING AGENCY

EMT Program Completed:	Location:	Graduation Date:
License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed	Original Date Issued:	Expiration Date:

**Questions:**

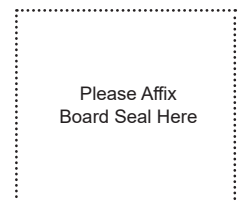
- Has this licensee ever been investigated by your office?  Yes     No
- Has this licensee incurred any disciplinary proceedings in your state, or is any action pending?  Yes     No
- Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation?  Yes     No
- Do you know of any information that may discredit this person?  Yes     No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Agency order, complaint, etc.).

Location of Course (Include printout of initial EMT course): \_\_\_\_\_ Date that Certificate was issued: \_\_\_\_\_

### Certification:

Signature	Date
Type or Print Name	Title
Full Name of Licensing Agency	



Please Affix Board Seal Here



## Rhode Island Department of Health Military Expedition Form

Please attach this form to the *front* of your completed application and mail to the address shown on the application cover.

Pursuant to Rhode Island General Laws § [5-88-1](#) et seq., upon application, this state may recognize occupational licenses, certificates or permits obtained from other states for military members and their spouses who relocate to this state pursuant to military orders. The Rhode Island Department of Health (RIDOH) will expedite your or your spouse's health professional license application provided the following conditions are met.

### I. PROFESSION/LICENSE TYPE

Please indicate the profession and/or license type you are applying for so that your application can be routed to the correct office:

Profession/License Type: \_\_\_\_\_

### II. MILITARY STATUS

Please check ONE of the following criteria for expedition:

I am in active military duty or a reservist.

I am the spouse of someone in active military duty or the spouse of a reservist.

I am a military veteran with honorable discharge. *You do not need to complete the rest of this application – please skip to the signature line.*

### III. PROOF OF MILITARY STATUS

Please attach a copy of proof of your military status such as one of the following: Leave Earning Statement (LES), Letter from Command, or Copy of Orders

### IV. MILITARY CHANGE OF STATION ORDER

Permanent Change of Station Order

### V. PROOF OF GOOD STANDING

Proof of good standing from the board in the other state in which the person has a license.

### VI. Criminal Background Check (a "BCI") (*unless required in the initial license application*)

BCI completed from the RI Attorney General's Office.

### VII. ATTESTATIONS:

Check all that apply:

No board in any other state has revoked the license for which I am applying as a result of negligence or intentional misconduct.

I have never surrendered an occupational license, certificate, or permit because of negligence or intentional misconduct.

I do not have a complaint, allegation, or investigation currently pending before a board in another state which relates to unprofessional conduct or an alleged crime.

I attest that the above responses and information are true and accurate to the best of my knowledge and that none of the information set forth above is false, erroneous, or defective in any important, as set forth in R.I. Gen. Laws § 11-18-1. I understand that this application is being made to the Rhode Island Department of Health, which shall rely upon my attestation and the information provided in this document.

Signature of Applicant

Date

*On a case-by-case basis RIDOH may grant a temporary license should the military member or spouse need additional time to complete education, training, and/or experience for the licensure in Rhode Island. RIDOH will contact the applicant directly should that be needed.*