



Rhode Island Division of Emergency Medical Services

Room 105, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-2401

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

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 Technician in the State of Rhode Island. The Rhode Island Division of Emergency Medical Services requires that the following form be completed by the jurisdiction in which I obtained my original training and/or licensure 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 |
| License Number | Date Issued | |

THIS SECTION TO BE COMPLETED BY THE EMS LICENSING AGENCY

| | | |
|--|---|------------------|
| EMT Program Completed: | Location: | Graduation Date: |
| Licensed by Examination? <input type="checkbox"/> Yes <input type="checkbox"/> No | Applicant has completed and passed both Written & Practical Exam: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 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.).

- Does this certification include use of: 1. Anti-shock Trousers (MAST)? Yes No 2. Esophageal Obturator Airway? Yes No
- Has this applicant completed course final exam or state practical exam to include the following practical skills: Airway Management, Traction Splint, Kendrick Extrication Device (KED) or Short Board, Long Spine Board, MAST, Patient Assessment? Yes No

Certification issued based on: Completion of a course in compliance with the U.S. Department of Transportation EMT National Standard Curriculum
 Reciprocity from the State of _____
 Reciprocity from the National Registry of Emergency Medical Technicians

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

Certification:

| | |
|--------------------|-------|
| Signature | Date |
| Type or Print Name | Title |

Please Affix Board Seal Here

Full Name of Licensing Agency