2024 ALS PROVIDER LICENSE / RENEWAL APPLICATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
EMERGENCY MEDICAL SYSTEMS UNIT
SFN 17393 (12/2023)

*This form **must** be completed in its entirety or it will be returned.* This form is required for all advanced level EMS personnel as application for state licensure and/or re-licensure. **An application must be submitted for each agency affiliation.** An EMS registration form is not required for ALS personnel. **Submit completed form to the Emergency Medical Systems Unit. Forms submitted without a medical director signature will be returned.**

REASON FOR APPLICATION SUBMISSION

☐ AEMT	☐ Paramedic	***Select if appropriate***	☐ Community Paramedic	☐ Critical Care Paramedic

PERSONAL AND EMPLOYMENT INFORMATION

ND State EMS Number	Social Security Number	National Registry Number		Date of Birth
First Name		Last Name		MI
Home Street Address / PO Box		City	State	ZIP Code
County		E-Mail Address		☐ Male ☐ Female
Home Telephone Number	Work Telephone Number	Cell Phone Number		
EMS Agency Affiliation (Complete Name - No Acronyms)	EMS Agency Affiliation (Number) ☐ Additional Affiliation ☐ Replacement Affiliation			
Do you receive monetary compensation as an EMS Provider? ☐ Yes ☐ No		If so, do you receive more than $10,000 per year? ☐ Yes ☐ No		

PRIVACY ACT STATEMENT

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Your social security number is being requested to permit the North Dakota Department of Health to verify your eligibility to become nationally registered and to properly conduct a criminal history background investigation pursuant to N.D.A.C section 33-36-01-05 before issuing licensure or certification. Disclosure of yoursocial security number is voluntary. If you are not willing to disclose your social security number, you must supply an official current criminal history background check to obtain licensure or certification as required to work as an EMS provider in North Dakota.

CRIMINAL CONVICTION STATEMENT – FORM WILL BE RETURNED IF THIS SECTION IS NOT COMPLETED.

☐ **Yes** ☐ **No** **1. Have you ever been convicted of any violation of any federal, military, state, or local laws (excluding non-criminal traffic violations?**

☐ **Yes** ☐ **No** **2. Have you ever had any license, certification, or right to practice denied or surrendered, or disciplined with suspension, reprimand, probation, revocation, or any other method of discipline in North Dakota or any other state or jurisdiction?**

☐ **Yes** ☐ **No** **3. Are you the subject of any pending investigation, administrative sanction proceeding, hearing, trial or similar action by an agency or board that has granted or denied you a license, certification, or right to practice in any regulated occupation, trade, or profession in North Dakota or in any other state or jurisdiction?**

☐ **Yes** ☐ **No** **4. If yes to either 1, 2, or 3 have you previously submitted this information / documentation to the EMS Unit?**

**If any of 1 - 3 above have been marked yes, you must provide official documentation that fully describes the offense, status, and disposition of the case if you have not submitted documentation in the past.*

AFFIRMATION SIGNATURE

I hereby affirm and declare that the above information is true and correct and that fraudulent entries may be sufficient cause for rejection or revocation. I understand that fraudulent entries may be considered a crime and may be prosecuted under state law. I further agree to notify the North Dakota Department of Health and Human Services Emergency Medical Systems Unit immediately if any changes in my status should occur and give permission to the Emergency Medical Systems Unit to perform a criminal background check.

Signature	Date

MEDICAL DIRECTOR AGREEMENT

The above-named person is employed by an ambulance service, rescue squad, or health care setting for which I am the Medical Director. Upon state licensure as an Advanced Level EMS Professional by the North Dakota Department of Health and Human Services of the person named above, I will provide medical direction consisting of verbal, written, or standing orders allowing the above-named person to provide medical care consistent with the skills defined by the North Dakota Scope of Practice.

I will assure that the person named above continues to remain competent in the skills contained in the North Dakota scope of practice. I have complete discretion as to which skills or treatment modalities listed in the North Dakota Scope of Practice for EMS Providers the above-named person may provide during the normal course of his/her duties. I understand that the above-named person is allowed to provide patient care to the level of licensure as a part of my practice and only as a result of my delegation of the authority to do so. I further understand that I may revoke this authority at any time. If I revoke this authority, I will provide the Emergency Medical Systems Unit with written notification of the revocation.

This agreement expires upon termination from the above-named agency or 90 days after National Registry Expiration.

Medical Director Signature	License Number	Date

SQUAD LEADER

Signature of squad leader / manager required ONLY when adding personnel to EMS agency roster.

Signature of listed agency's squad leader / manager on record	Date

This form may be completed and mailed to:

Department of Health and Human Services
Emergency Medical Systems Unit
1720 Burlington Dr – Suite A
Bismarck ND 58504-7736

You may also submit the completed form via email to dems@nd.gov or via fax at 701-328-0357.

Our website is: www.hhs.nd.gov.

For questions, call our office at 701-328-2388 or e-mail us at dems@nd.gov.