



Complete this form electronically or by hand. Provider license must be current to receive award.

Organization
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Provider Nominated	Certification Level

Location of Delivery (ambulance, residence, etc.)	
Delivery Date	Delivery Time
Parent(s) Name(s)	Parent(s) Name(s)
Baby boy	Baby girl

Send Award To:

Name of Organization		
Address		
City	State	ZIP Code
Contact Telephone		
Signature	Date	

For HHS Use Only:

Approved	Not Approved
Signature	
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  
e-mail to [dems@nd.gov](mailto:dems@nd.gov) or via fax at 701-328-0357.

Our website is: <https://www.hhs.nd.gov/health/EMS>

For questions, call our office at 701-328-2388 or e-mail us at [dems@nd.gov](mailto:dems@nd.gov).