



2010- 2011 EMS PROVIDER RENEWAL APPLICATION



PLEASE PRINT NEATLY IN INK OR TYPE ---- APPLICATION MUST HAVE ORIGINAL SIGNATURES

EMS License # Social Security # Date of Birth

Last Name First Name Middle Initial

Gender: Male Female Has your name changed since your last renewal? Yes No

If yes, previous name

Make checks, money orders or purchase orders payable to the EMS Bureau. Do Not send cash

RETURN RENEWAL PACKET TO: NM EMS BUREAU
ATTN: Tess Pino
1301 Siler Rd; Bldg F
Santa Fe, NM 87507

RENEWAL LEVEL (CHECK ALL THAT APPLY)

Table with 3 columns: Emergency Medical Dispatcher, EMS First Responder, EMT-Basic, EMD-Instructor, EMT-Intermediate, EMT-Paramedic

ADDRESS

Mailing Address Apt#
City State Zip Code
NM County E-Mail Address
Home Phone: Cell Phone:

EMPLOYMENT INFORMATION

Name of Employer Work Phone
Work E-Mail Address:

RACE (Optional-For Statistical Purposes Only)

Asian Black Caucasian Hispanic
Native American Pacific Islander Alaskan Native Other

SERVICE AFFILIATION

Table with 2 columns: Primary Service, Secondary Service. Includes fields for Name, Service #, and Paid/Volunteer/Both status.

FOR EMS BUREAU USE ONLY:
Check/P.O./ Money Order # Date \$ logged: Amt. \$ Initials

**MEDICAL DIRECTION
COMPLETION OF THIS SECTION IS MANDATORY**

THIS SECTION MUST BE COMPLETED BY ALL FIRST RESPONDERS AND BASICS

(1) If you are not currently with a service, your service does not perform any advanced techniques, medications and/or procedures, read the following statement and initial.

I hereby certify that as a Licensed EMS First Responder or EMT-Basic, I do not perform any advanced techniques, medications, and/or procedures as outlined in the annual New Mexico Scopes of Practice.

INITIAL HERE: _____ **OR**

(2) If your service authorizes the use of any advanced techniques, medications and/or procedures, including Semi-Automatic Defibrillation or use of multi-lumen airways, you must have your medical director certify your competency by signing below.

As Medical Director for _____, I hereby certify that the applicant is competent in all required advanced techniques, medications, and/or procedures as outlined in the annual New Mexico Scopes of Practice.

Print Medical Director Name _____ MD License # _____

Medical Director Signature _____

MUST BE COMPLETED BY INTERMEDIATES AND PARAMEDICS

EMT-Intermediates or EMT-Paramedics not currently providing care through a an EMS provider service and do not have a service medical director, may, for good cause, petition the bureau in writing, for an exception to this requirement.

As Medical Director for _____, I hereby certify that the applicant is competent in all required advanced techniques, medications, and/or procedures as outlined in the annual New Mexico Scopes of Practice.

Print Medical Director Name _____ License # _____

Medical Director Signature _____ Date _____

APPLICANT SIGNATURE

(If you answer "yes" to any question below, please attach supporting documentation)

Since your last license renewal, have you been convicted of any misdemeanor or felony under the laws of any state, the United States, or a foreign country? (Minor traffic violations need not be reported; any conviction involving driving while impaired, DUI, DWI, etc., *MUST* be reported.) _____ Yes _____ No

Are you presently addicted to alcohol or any controlled substance? _____ Yes _____ No

Has any certification/licensure action been taken against you in any other state or municipality including denial, suspension or revocation: If yes, please attach an explanation and documentation. _____ Yes _____ No

Do you currently have pending court charges; or court ordered interlock devices installed since your last renewal? _____ Yes _____ No

I hereby affirm that the information is true and correct and agree that any fraudulent entry may be considered sufficient cause for denial, suspension, or revocation of my licensure.

Applicant's Signature _____ Date _____
(MUST BE ORIGINAL SIGNATURE No copies or faxes will be accepted)