



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
 BUREAU OF EMERGENCY MEDICAL SERVICES  
**EMS PERSONNEL LICENSE APPLICATION**

**UEMS USE ONLY**

**FOR DOH OFFICE USE ONLY DO NOT WRITE IN THIS SPACE**

EMT LICENSE NO. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	APPROVED BY/DATE _____	DATE LICENSED <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
DATE APP. REC'D. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		EXPIRATION DATE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

**APPLICANT MUST COMPLETE INFORMATION BELOW TYPE OR PRINT**

1. <input type="checkbox"/> INITIAL LICENSE APP.	CURRENT MO EMS LIC NO. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	EXPIRATION DATE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
2. <input type="checkbox"/> RELICENSURE APP.	<b>IF APPLICABLE</b>	<b>AND</b>

3. TYPE OF LICENSE APPLIED FOR (Check One)    **EMT-Basic**     **EMT-Intermediate**     **EMT-Paramedic**

4. CERTIFICATION/EDUCATION USED FOR INITIAL LICENSURE OR RELICENSURE: (PLEASE CHECK ONLY ONE)

<input type="checkbox"/> EMT-B NATIONAL REGISTRY (Attach copy of card)	<input type="checkbox"/> EMT-I NATIONAL REGISTRY (Attach copy of card)	<input type="checkbox"/> EMT-P NATIONAL REGISTRY (Attach copy of card)	<input type="checkbox"/> EMT-B CONTINUING EDUCATION	<input type="checkbox"/> EMT-I CONTINUING EDUCATION	<input type="checkbox"/> EMT-P CONTINUING EDUCATION
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5. NAME (LAST, FIRST, MIDDLE INITIAL)

SOCIAL SECURITY NUMBER	DATE OF BIRTH MO ___ DAY ___ YR ___	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DAYTIME PHONE NUMBER _____-_____-_____ E-MAIL ADDRESS (if applicable)
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MAILING ADDRESS (STREET)

CITY	STATE	ZIP CODE	COUNTY
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6. NAME OF THE EMS AGENCY YOU ARE CURRENTLY WORKING FOR.(If applicable)

7. TYPE OF PRESENT PRIMARY EMS AFFILIATION (IF APPLICABLE)

<input type="checkbox"/> AMBULANCE SERVICE	<input type="checkbox"/> UNLICENSED FIRST RESPONDER AGENCY	<input type="checkbox"/> POLICE DEPARTMENT
<input type="checkbox"/> LICENSED EMRA	<input type="checkbox"/> FIRE SERVICE	<input type="checkbox"/> OTHER

8. Have you ever had administrative licensure action taken against your EMT license in Missouri or any other state?  
 Yes  No  IF YES, EXPLAIN ON ATTACHED SHEET

9. Has your right to practice in a health care occupation ever been subject to limitation, suspension, or termination?  
 Yes  No  Not applicable  IF YES, EXPLAIN ON ATTACHED SHEET

10. Have you ever voluntarily surrendered a health care license or certification in any state?  
 Yes  No  Not applicable  IF YES, EXPLAIN ON ATTACHED SHEET

11. HAVE YOU EVER BEEN FINALLY ADJUDICATED AND FOUND GUILTY, OR ENTERED A PLEA OF GUILTY OR NOLO CONTENDERE IN A CRIMINAL PROSECUTION UNDER THE LAWS OF ANY STATE OR OF THE UNITED STATES, WHETHER OR NOT YOU RECEIVED A SUSPENDED IMPOSITION OF SENTENCE FOR ANY CRIMINAL OFFENSE?    Yes  No

IF YOU HAVE ANSWERED YES TO THE ABOVE QUESTION YOU MUST ATTACH TO YOUR APPLICATION A CERTIFIED COPY OF ALL CHARGING DOCUMENTS (SUCH AS COMPLAINTS, INFORMATIONS OR INDICTMENTS), JUDGMENTS AND SENTENCING INFORMATION AND ANY OTHER INFORMATION YOU WISH CONSIDERED.

12. I HEREBY CERTIFY THAT:

- A. I am able to speak, read and write the English language.
- B. I do not have a physical or mental impairment which would substantially limit my ability to perform the essential functions of an emergency medical technician with or without a reasonable accommodation.
- C. This application contains no misrepresentations or falsifications and the information given by me is true and complete to the best of my knowledge. I further certify that I have both the intention and the ability to comply with the regulations promulgated under Chapter 190, RSMo
- D. I have been a resident of Missouri for five (5) consecutive years prior to the date on the application or I have attached to the application at least two (2) completed fingerprint cards supplied by the EMS Bureau.

IF RELICENSING USING CONTINUING EDUCATION, PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM

APPLICANT'S SIGNATURE	DATE
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**WARNING:** In addition to licensure action, anyone who knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty may be guilty of a class B misdemeanor, Missouri Statutes 575.060.





