MAINE EMERGENCY MEDICAL SERVICES
VERIFICATION OF EMS CERTIFICATION/LICENSURE

TO BE COMPLETED BY THE APPLICANT

A verification form is required for each state you currently hold a certification/license

Name: FIRST _____ MIDDLE _____ LAST _____

Social Security Number: _____ **Date of Birth:** (mm/dd/yyyy) _____

State of Certification/Licensure: _____ **Certification/License #:** _____

TO BE COMPLETED BY THE STATE EMS OFFICE:

The above named individual is applying for Maine EMS Licensure and reported current credentials from your agency. Please complete the following with information regarding all current credentials your agency has issued and **return this form directly to our office by fax or email**. Please call 207-626-3860 with any questions or concerns.

	Issue Date	Expiration Date	Notes / Comments
EMT / EMT-Basic			
EMT-I (85)			
Advanced EMT			
Please indicate any of the following included in the training:	☐Adult IO ☐Manual Defibrillation		☐CPAP ☐12 Lead Acquisition ☐Cardiac Monitoring
EMT-I (99)			
Paramedic / EMT-Paramedic			
Other:_____			

Is this applicant's certification/license in good standing?	**Has there ever been any licensing/disciplinary action taken against the applicant's certification/license by your state?**
☐Yes ☐No (please attach documentation of the incident)	☐Yes (please attach documentation of the incident) ☐No

Individual Verifying **(Print)**	Title
Individual Verifying **(Signature)** Date	E-mail address
Licensing Agency	Phone Number

PLEASE RETURN THIS DOCUMENT DIRECTLY TO MAINE EMS	
Fax: 207-287-6251 **Attn:** EMS Licensure	**Email:** ems.licensure@maine.gov

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