County of Santa Clara
Emergency Medical Services System

Policy # 901
EMS Personnel Application

EMT CERTIFICATION:	PARAMEDIC ACCREDITATION:	OTHER BUSINESS:
❑ Initial Application	❑ Initial Application	❑ Change of Address
❑ Renewal Application	❑ Renewal Application	❑ Change of Name
❑ State EMT Card Replacement		❑ Other:

EMS SYSTEM IDENTIFICATION BADGE:

❑ EMT	❑ Paramedic Preceptor	❑ Supervisor Accreditation	❑ MVDR
❑ Paramedic	❑ CCT Nurse	❑ EMS Manager	❑ Other:
❑ Paramedic Intern	❑ MICN Authorization	❑ County Ambulance Staff	

Last Name: ______________________ Alias/Maiden Name: ______________

First Name: ______________________ Middle Name: ______________

Mailing Address: ______________________________________

City: ______________ State: __________ Zip: ________

Home Phone: (______) ______________ Cellular Phone: (______) ______________

SSN: ______/______/______ Date of Birth: ______/______/______

Email: ______________________________________

If you are currently or have been previously certified, licensed, or accredited; please provide the following:

Type: ______________________ Agency Issuing: ______________________

Expiration Date: ______/______/______ Certification/license Number: ______________

TO BE COMPLETED BY YOUR SANTA CLARA COUNTY EMS PROGRAM MANAGER ONLY

The individual named on this application is currently employed by ______________________________. Copies of employees' records are on file and available to the Agency upon request. As the authorized representative of the agency named above, I will notify the Santa Clara County EMS Agency immediately of any change in employment with the individual named on this application.

EMS Program Manager Signature: ______________________ Date: __________

Paramedic Accreditation Authorization Signature by EMS Program Manager: ______________________

PARAMEDIC INTERN RECOGNITION (TO BE COMPLETED BY PARAMEDIC TRAINING PROGRAM DIRECTOR)

As the Paramedic Training Program Director, I certify that the individual named on this application is approved to begin field internship. I further certify that the program will monitor the individual throughout the field evaluation of the paramedic training program.

Paramedic Program Name: ______________________ Phone #: (______) ______________

Internship Provider Agency: ______________________________________

Preceptors Name & License Number: ______________________________________

Program Director Name & Signature: ______________________________________

Applicant's Name:____

Any of the following violations of the California Health and Safety Code, Section 1798.200(c) shall be considered evidence of a threat to the public health and safety and may preclude the applicant from certification, as listed below:

(1) Fraud in the procurement of a certificate or license under this division.
(2) Gross negligence.
(3) Repeated negligent acts.
(4) Incompetence.
(5) The commission of any fraudulent, dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of pre-hospital personnel.
(6) Conviction of any crime which is substantially related to the qualifications, functions and duties of pre-hospital personnel. The record of conviction or certified copy of the record shall be conclusive evidence of such conviction.
(7) Violation or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this division or the regulations promulgated by the authority pertaining to pre-hospital personnel.
(8) Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances.
(9) Addiction to the excessive use of, or the misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.
(10) Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by any other license or certification.
(11) Demonstration of irrational behavior or occurrence of a physical disability to the extent that a reasonable and prudent person would have reasonable cause to believe that the ability to perform the duties normally expected may be impaired.
(12) Unprofessional conduct.

YES	NO	
❑	❑	Have you ever had a certification, license, accreditation, or professional license denied, suspended, revoked or placed on probation, or are under investigation or review at this time?
❑	❑	Have you ever been have you been convicted of a crime (misdemeanor or felony), plead guilty, including nolo contendere, accepted a plea bargain, or been given a suspended sentence by any court (traffic, criminal, military); been placed on probation, placed on parole, been made ward of any court, including any conviction which has been expunged (set aside) or records sealed or have been placed on censure?
❑	❑	Are you currently of parole and/or probation following the conviction of any crime?
❑	❑	Are there any local, State or Federal charges pending against you?

If "Yes" to any of the above listed questions, provide a written statement explaining the circumstances.
❑ Check here if previously disclosed and on file with the Santa Clara County EMS Agency.

Applicants may request a copy of their Criminal Offender Record Information (CORI) generated by the Department of Justice (DOJ) and Federal Bureau of Investigation fingerprint submission. If after review it is believed that the information is incorrect or incomplete you may submit an application for change by:

1. Submitting the letter of application for change directly to the agency which contributed the questioned information.
2. Submitting the letter of challenge as to the accuracy or completeness of any entry to the FBI, Criminal Justice Information Services (CJIS) Division. ATTN: SCU, Mod. D-2, 1000 Custer Hollow Road, Clarksburg, WV 26306

Declaration

I hereby certify under penalty of perjury that all information on this application is true and correct to the best of my knowledge and belief, and I understand that any falsification or omission of material facts may cause forfeiture on my part of all rights to EMT certification in the state of California. I understand all information on this application is subject to verification, and I hereby give my express permission for this certifying entity to contact any person or agency for information related to my role and function as a prehospital provider in California. I understand incomplete applications will not be processed and are subject to denial.

Applicant Signature:____ Date:____/____/____

Document executed in the City of:_________________________________ State:_____________