

INCOMPLETE Application will not be accepted. Please notify the EMS Office in writing of any address change(s) after you file this application in order to receive any further notice.



**Department of Public Health & Social Services
Office of Emergency Medical Services**

194 Hernan Cortez Avenue, Suite 213A Terlaje Professional Building Hagatna, Guam 96910
(671) 735-7411 or (671) 735-7412



PL 31-146:2 (Chapter 84): CHECKLIST Attached.

Police/Court Clearances: **Not more than 2 months from date of Application Request.** EMTs Must NOT be felons on substance, alcohol abuse, and NOT be on the Sexual Registry. Necessary for reporting to the National Data Bank enforced by EMS due to federal mandate, DOHHS for all emergency care providers, hospitals, and Medicare service providers. (PL 31-146 pgs. 12-13 authority to EMS Office to make changes to policy and create R&R as approved by EMS Commission to meet DOT regulations). **Social Security Act (mandatory), REF:** child-support, spousal/alimony order, repayment of educational loans.

Application requirements must be received by the EMS Office prior to the EMS Commission's monthly scheduled meeting for the Commission's review.

APPLICATION FOR:

CERTIFICATION RECIPROCATATE RECERTIFICATION UPDATE TEMPORARY LAPSE/REINSTATEMENT

Date Receive/By: _____ EM-D EMR EMT ALS AEMT

NREMT Number: _____ EXPIRATION DATE: _____

GUAM EMT No: _____ STATE /NUMBER: _____ EXPIRATION: _____

APPROVE DISAPPROVE _____ DATE: _____

ZENNIA C. PECINA, RN, MSN EMS Administrator

COMMENT (S) : _____

A. PERSONAL IDENTIFICATION: () Mr. () Miss () Mrs.

B. Gender: Male Female Transgender Gender Non-Conforming

1. PRINT Full Name: _____ MAIDEN: _____
 LAST FIRST Middle

2. Email Address: _____ Birthdate: _____ Soc Sec No: _____

3. Mailing Address: _____

4. Home Address: _____

5. Home Phone: _____ Radio/Cell Phone: _____ Other contact #: _____

6. Occupation _____ Employer: _____ Work Phone: _____

7. If employed by a Non-Emergent Transport Company, please check (v) one:
 () Access Medical Transport () Marianas Medical Response () Other: _____
 () Priority One Transport
 Name of Medical Director: _____

8. Employer's Address: _____

C. EDUCATION: HIGH SCHOOL GRAD GED COLLEGE LEVEL: 1 2 3 4

D. Approved EMTs/EMD/EMR/ALS COURSES: ATTACH Certificate of Completion Course. Training Program must include all objective of the current national Standard Curriculum/APCO, etc.

Course Title	Hours	Dates	Sponsored By	Instructor
1. EMT/AEMT/ALS/EMT-P				
2. EMD/EMR				

E. Have you ever been convicted of a felony? Yes No

If YES: Please attach documentation that fully describes the offense, copies of relevant court documents, deposition and current status.

I understand that my application will not be accepted for processing until it has been completed in its entirety and I hereby affirm and declare that the above information is true and correct and that any fraudulent entry may be considered cause for rejection or subsequent revocation. It is also understood that the Guam EMS Office may conduct an audit of the registration activities reported on these forms any time.

AFFIDAVIT

To be sworn before an Officer authorized to administer OATHS by the applicant who has completed this form, and is applying for Guam Certification.

Applicant's Signature

Subscribed and sworn to before me this _____ Day of _____

Notary Public _____
Commission Expires: _____

Date

NOTARY SEAL