NORTH Dakota
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2023 EMS REGISTRATION FORM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
EMERGENCY MEDICAL SYSTEMS UNIT
SFN 52195 (12/2022)

*This form **must** be completed in its entirety, or it will be returned.* This form must be completed by:

1. Students in EMT, AEMT, and Paramedic courses and submitted by the course coordinator upon **starting** the course.
2. Students in EMR, EMD, EVOC, or Auto Extrication courses and submitted by the course coordinator with the course roster upon **course completion**.
3. Basic level EMS personnel as application for state licensure and/or re-licensure.
4. Any BLS personnel requesting to be added to an EMS agency roster (a form signed by the squad leader/manager is required for each agency being added to) or requesting name/address changes. Note: Squad leaders have on-line access to their rosters and may make personnel changes through the website.

ALS Providers must complete an ALS license application signed by their medical director to apply for licensure.

REASON FOR APPLICATION SUBMISSION

☐ AFAA License	☐ EMT Student	☐ Auto Extrication	☐ Dispatch
☐ EMR License	☐ AEMT Student	☐ Driver w/CPR (Must include copy of CPR card)	☐ EVOC
☐ EMT License	☐ Paramedic Student	☐ CEC/IC	☐ Registered Nurse (Must include copy of license)
☐ State EMT License (ND State license < 18 years of age)		☐ Other	Please specify 'other' level

PERSONAL AND EMPLOYMENT INFORMATION

ND State EMS Number	Social Security Number	National Registry Number (or other)	Date of Birth
First Name		Last Name	MI
Home Street Address / PO Box	City	State	Zip Code
County	E-Mail Address	☐ Male ☐ Female	
Home Telephone Number	Work Telephone Number	Cell Phone Number	
EMS Agency Affiliation (Complete Name - No Acronyms)	EMS Agency Affiliation (Number) ☐ Additional Affiliation ☐ Replacement Affiliation		
Course Authorization Number (Obtain from instructor – for initial class registration only)		Course Completion Date	
Do you receive monetary compensation as an EMS Provider? ☐ Yes ☐ No		If so, do you receive more than $10,000 per year? ☐ Yes ☐ No	

PRIVACY ACT STATEMENT

Your social security number is being requested to permit the North Dakota Department of Health to verify your eligibility to become nationally registered and to properly conduct a criminal history background investigation pursuant to N.D.A.C section 33-36-01-05 before issuing licensure or certification. Disclosure of your social security number is voluntary. If you are not willing to disclose your social security number, you must supply an official current criminal history background check to obtain licensure or certification as required to work as an EMS provider in North Dakota.

CRIMINAL CONVICTION STATEMENT – FORM WILL BE RETURNED IF THIS SECTION IS NOT COMPLETED.

☐ **Yes** ☐ **No** **1. Have you ever been convicted of any violation of any federal, military, state, or local laws (excluding non-criminal traffic violations?**

☐ **Yes** ☐ **No** **2. Have you ever had any license, certification, or right to practice denied or surrendered, or disciplined with suspension, reprimand, probation, revocation, or any other method of discipline in North Dakota or any other state or jurisdiction?**

☐ **Yes** ☐ **No** **3. Are you the subject of any pending investigation, administrative sanction proceeding, hearing, trial or similar action by an agency or board that has granted or denied you a license, certification, or right to practice in any regulated occupation, trade, or profession in North Dakota or in any other state or jurisdiction?**

☐ **Yes** ☐ **No** **4. If yes to either 1, 2, or 3 have you previously submitted this information / documentation to the EMS Unit?**

**If any of 1 - 3 above have been marked yes, you must provide official documentation that fully describes the offense, status, and disposition of the case if you have not submitted documentation in the past.*

I hereby affirm and declare that the above information is true and correct and that fraudulent entries may be sufficient cause for rejection or revocation. I understand that fraudulent entries may be considered a crime and may be prosecuted under state law. I further agree to notify the Department of Health and Human Services Emergency Medical Systems Unit immediately if any changes in my status should occur and give permission to the Emergency Medical Systems Unit to perform a criminal background check.	
Signature	Date

Signature of squad leader / manager required ONLY when adding new personnel to EMS agency roster.

Signature of listed agency's squad leader / manager on record	Date

This form may be completed and mailed to:

Department of Health and Human Services
Emergency Medical Systems Unit
1720 Burlington Dr – Suite A
Bismarck ND 58504-7736

You may also submit the completed form via e-mail to dems@nd.gov or via fax at 701-328-0357.

Our website is: www.hhs.nd.gov

For questions, call our office at 701-328-2388 or e-mail us at dems@nd.gov.