

Michigan Department of Health and Human Services
 Emergency Medical Services Section
 P.O. Box 30437
 Lansing, MI 48909
 Phone 517-241-0179 Fax 517-335-9434
VERIFICATION OF OUT-OF-STATE LICENSURE

Authority: Public Act 368 of 1978, as amended.

PART I – To be completed by the applicant and forwarded by the applicant to the appropriate State Licensing Agency for completion of PART II. If your out of state education does NOT meet Michigan requirements, you will be required to take additional education to meet Michigan’s standards.

Please indicate the level of licensure for which you are requesting verification:		
<input type="checkbox"/> Medical First Responder	<input type="checkbox"/> Emergency Medical Technician	<input type="checkbox"/> Specialist-AEMT <input type="checkbox"/> Paramedic
First Name	Middle Name	Last Name
All Previous Names and/or Birth Names Used (if applicable)	Date of Birth	Social Security Number
State Agency	License Number	Date INITIAL license was issued
Nationally Registered through NREMT? <input type="checkbox"/> Yes <input type="checkbox"/> No	National Registry #	National Registry Status <input type="checkbox"/> Active <input type="checkbox"/> Lapsed

PART II – To be completed by the State Licensing Agency.

The applicant named above has applied for licensure in Michigan and has indicated licensure in your state. Please complete Part II of this form and return it to the address shown above.

License Type	License Status <input type="checkbox"/> Active <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive	Expiration Date
Has the applicant incurred any disciplinary proceedings in your State? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please attach certified copies of any actions.)		Are disciplinary proceedings pending? <input type="checkbox"/> No <input type="checkbox"/> Yes
Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended, or revoked? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please attach certified copies of any actions.)		
If applying for MFR , did the applicant's training include: <input type="checkbox"/> Spinal Immobilization <input type="checkbox"/> Epi-Pen® <input type="checkbox"/> Narcan® Administration		
If applying for EMT , did the applicant's training include: <input type="checkbox"/> Supraglottic Airway (e.g., combitube, king) <input type="checkbox"/> CPAP <input type="checkbox"/> Epi-Pen® <input type="checkbox"/> Albuterol® <input type="checkbox"/> Narcan® Administration		
If this person is currently licensed as a Specialist (AEMT) or Paramedic, do they currently hold or have they held in the past, certification/licensure at the EMT level? <input type="checkbox"/> No <input type="checkbox"/> Yes		

CERTIFICATION

I hereby certify that, to the best of my knowledge, the information above is true to the records of this Licensing Agency.

Signature	Date
Type or Print Name	Title
Name of Licensing Agency	(S E A L)
Phone Number	

The Department of Health and Human Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency