

**Form 202**

**Connecticut Department of Public Health  
Office of Emergency Medical Services**

Type of Application:  MRT  EMT  EMT-I

**Please check one below:**

Initial (new course only)  Endorsement  Recertification  Reinstatement: Certification No. \_\_\_\_\_ Expiration: \_\_\_\_\_

Temporary EMT permit: CT EMT certification No.: \_\_\_\_\_ Expiration: \_\_\_\_\_  
CT Paramedic License No.: \_\_\_\_\_ Expiration: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_/\_\_\_/\_\_\_ Gender:  Male  Female

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Please indicate the address to which your official certification documents, as well as all future mailings from this Department shall be sent (please type or print).

Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Are you, or have you ever been, licensed, certified or registered as an EMS provider in any state or territory?  Yes  No. If yes, list all states or territories

Are you now, or has the National registry ever certified you?  Yes  No. If yes, please indicate certification No. \_\_\_\_\_

Are you presently working in your licensed/certified profession?  Yes  No. If yes, please indicate hours of practice per week \_\_\_\_\_

Provider Information (If presently affiliated): Name of Service: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Work Email: \_\_\_\_\_

Fax Number: \_\_\_\_\_

*At the exam, do you require accommodation for any disabling condition? Yes  No . If yes, please submit a written statement briefly describing the nature of your disability and the accommodation you are seeking. Please mail the request for accommodation directly to the National registry at 6610 Busch Blvd., PO 29233, Columbus, OH 43229, and attach a separate copy of the statement to the EMT application (202). Upon review of your request, this office and the National Registry will contact you regarding your request..*

**PROFESSIONAL HISTORY: Answer 1-8 by checking YES or NO. If you answer YES, follow directions below.**

1. Have you ever been censured, disciplined, dismissed or expelled from, had admissions monitored or restricted, had privileges limited, suspended or terminated, been put on probation, or been requested to resign or withdraw from any of the following:
  - Any hospital, nursing home, clinic or similar institution;
  - Any health maintenance organization, professional partnership, corporation, or similar health practice organization, either private or public;
  - Any professional school, clinical clerkship, internship, externship, preceptorship or postgraduate training program;
  - Any third party reimbursement program, whether governmental or private?

YES  NO
  
2. Have you ever had your membership in or certification by any professional society or association suspended or revoked for reasons related to professional practice?
 

YES  NO
  
3. Has any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or foreign jurisdiction, limited, restricted, suspended or revoked any professional license, certificate, or registration granted to you, or imposed a fine or reprimand, or taken any other disciplinary action against you?
 

YES  NO
  
4. Have you ever, in anticipation or during the pendency of an investigation or other disciplinary proceeding, voluntarily surrendered any professional license, certificate or registration issued to you by any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction?
 

YES  NO
  
5. Have you ever been subject to, or do you currently have pending, any complaint, investigation, charge, or disciplinary action by any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction or any disciplinary board/committee of any branch of the armed services? You need not report any complaints dismissed as without merit.
 

YES  NO

6. Have you ever been denied or surrendered a state or federal controlled substance registration, had it revoked or restricted in any way, or been warned, reprimanded, or fined by the responsible agency? YES  NO

If your answer is "yes" to any of the above questions (1-6), please give full details, names, addresses, etc. on a separate NOTARIZED statement.

7. Have you ever entered into, or do you currently have pending, a consent agreement of any kind, whether oral or written, with any professional licensing or disciplinary body of state, the District of Columbia, a United States possession or territory, any branch of the armed services or a foreign jurisdiction? YES  NO

If "yes", give full details, names, addresses, etc. on a separate NOTARIZED statement. Also submit a NOTARIZED copy of the agreement.

8. Have you ever been found guilty or convicted as a result of an act which constitutes a felony under the laws of this state, federal law or the laws of another jurisdiction and which, if committed within this state, would have constituted a felony under the laws of this state? YES  NO

YES  NO

If "yes", give full details, dates, etc. on a separate NOTARIZED statement and furnish a Certified Court Copy (with court seal affixed) of the original complaint, the answer, the judgment, the settlement, and/or the disposition.

I have reviewed the information and verify that it is accurate. I certify under penalties of perjury that I have not been convicted of a crime involving moral turpitude within the past three years, nor am I addicted to the use of drugs or alcohol. I certify that I am the person on this application and that all statements are true and correct.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**TO BE COMPLETED BY TRAINING PROVIDER ONLY**

For All Courses: The course was an:  Initial  Refresher training program for:  MRT  EMT  EMT-I

Dates of Course: MRT- Basic/Refresher – From: \_\_\_\_\_ To: \_\_\_\_\_ Course Location: \_\_\_\_\_

EMT- Basic/Refresher – From: \_\_\_\_\_ To: \_\_\_\_\_ Course Location: \_\_\_\_\_

EMT-I – Basic/Refresher – From: \_\_\_\_\_ To: \_\_\_\_\_ Course Location: \_\_\_\_\_

EMS-I Certification Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

For Connecticut Courses only: MRT – Basic/Refresher CT Course Approval Number: \_\_\_\_\_ Course Hours: \_\_\_\_\_  
 EMT – Basic/Refresher CT Course Approval Number: \_\_\_\_\_ Course Hours: \_\_\_\_\_  
 EMT-I Basic/Refresher CT Course Approval number: \_\_\_\_\_ Course Hours: \_\_\_\_\_

I certify that the applicant successfully completed a written and practical examination at the conclusion of this course.  YES  NO

I certify that the above named applicant successfully completed the above training program, including written and practical exams, and that such program met the requirements of DPH Regulations or, if outside of Connecticut, adhered to the U.S. COT, NHTSA National Standard Curriculum.

\_\_\_\_\_  
Signature of Course Instructor/Coordinator

(860) 496-6656  
\_\_\_\_\_  
Daytime Phone No.

\_\_\_\_\_  
Date

Paul Rabeuf EMS Coordinator The Charlotte Hungerford Hospital prabeuf@hungerford.org

\_\_\_\_\_  
Printed Name of Course Instructor/Coordinator

\_\_\_\_\_  
E-Mail Address

\_\_\_\_\_  
Signature of Course Medical Director (For EMT-I courses only)

\_\_\_\_\_  
Connecticut Physician Lic. No.

\_\_\_\_\_  
Date

Please mail or fax (860) 509-7987, this form directly to: CT Department of Public Health, EMS Certification, 410 Capitol Ave., MS #12 EMS, PO Box 340308, Hartford, CT 06134-0308. Should you have any questions, please contact this office at (860) 509-7558.

**IMPORTANT:** The application packet for this profession consists of 18 pages, including, instructions and eligibility requirements. Do not send this application unless you have read and understood all pertinent information.