

Amt Rec'd: _____

Check/MO: _____

Receipt No.: _____

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH
EMERGENCY MEDICAL SYSTEMS

NV EMS #: _____

AMBULANCE AND FIRE AGENCY ATTENDANT APPLICATION

This application must be completed and submitted to the State EMS Office, (address listed on back). Please indicate below if this is an initial or a renewal and include the documentation requested for that process.

Initial Attendant Application

- A. Two full sets of fingerprints (forms available at regional offices) and a business check or money order in the amount of \$51.25 made payable to the Department of Public Safety.**
- B. A check or money order for \$10.00** made payable to: Nevada State Health Division.**
- C. If in the last 6 months you were a resident of a state other than Nevada, submit a current driving record provided by the Department of Motor Vehicles of that state.**

Renewal Attendant Application

- A. A check or money order for \$5.00** made payable to: Nevada State Health Division.**
- B. If you are a resident of a contiguous state (i.e.: Utah, California, Idaho, Oregon, Arizona) and are working in Nevada, provide a current driving record provided by the Department of Motor Vehicles of that state.**

Name: _____
(Last) (First) (Middle)

Address: _____
(Street/P.O. Box) (City) (State) (Zip)

Phone: _____ / _____ Email Address: _____
(Home) (Work)

Type of Attendant: Volunteer Paid Air

Name of Service you intend to be associated with: _____ Permit # _____

1. PERSONAL INFORMATION:

S.S. #: _____ D.L. #: _____ State of Issue: _____

Date of Birth: _____ Male Female

**\$25.00 fee on all returned checks

| | | | |
|---|--|---|---|
| (EMS Office Use Only) | | | |
| Reviewed by: _____ | Date: _____ | Approve: <input type="checkbox"/> | Air: <input type="checkbox"/> Expiration Date: _____ |
| Deny: <input type="checkbox"/> Reason for Denial: _____ | | | |
| Application complete: <input type="checkbox"/> | DMV printout: <input type="checkbox"/> | Fingerprint Cards w/fee: <input type="checkbox"/> | Valid Certificate: <input type="checkbox"/> Altitude Physiology (for Air): <input type="checkbox"/> |
| Date Entered in Database: _____ | | Date Printed: _____ | |

All applicants must provide proof of skills retention at the Basic level. In addition, Intermediate and Advanced EMTs must provide proof of skills retention at their respective levels.

Basic Skills – To be completed by all applicants

| Skill | Date | Pass | Fail | Print Evaluator's Name | Evaluator's Signature (Sign in BLUE ink) |
|---|------|------|------|------------------------|--|
| Mouth to Mask | | | | | |
| Airway Maintenance | | | | | |
| Oxygen Administration | | | | | |
| (Semi) Automatic External Defibrillator | | | | | |
| Patient Assessment | | | | | |
| Bleeding Control / Shock Management | | | | | |
| Immobilization (Bone, Joint, Traction) | | | | | |
| Spinal Immobilization | | | | | |

Intermediate Skills – To be completed by all Intermediate EMTs

| Skill | Date | Pass | Fail | Print Evaluator's Name | Evaluator's Signature (Sign in BLUE ink) |
|---------------------------|------|------|------|------------------------|--|
| Airway EOA/EGTA | | | | | |
| Endotracheal | | | | | |
| Combitube/PTL | | | | | |
| I.V. | | | | | |
| Intra Ossous Infusion | | | | | |
| Medication Administration | | | | | |

Advanced Skills - To be completed by all Advanced EMTs (Paramedics)

| Skill | Date | Pass | Fail | Print Evaluator's Name | Evaluator's Signature (Sign in BLUE ink) |
|-----------------------------------|------|------|------|------------------------|--|
| 1.Ventilatory Management | | | | | |
| 2.Cardiac Arrest Management | | | | | |
| 3.Cardiac Dysarrythmia Management | | | | | |
| 4.Intravenous Infusion | | | | | |
| 5.Intraosseous Infusion | | | | | |
| 6.Medication Administration | | | | | |
| 7.Chest Decompression | | | | | |
| 8.NG Tube | | | | | |

The statement below must be signed by either the course physician of record or a qualified instructor:

I have tested the above-named person for the skills shown.

- He/she has been found competent in the administration of these skills to my satisfaction
- He/she has **not** been found competent in the administration of these skills to my satisfaction.
- I recommend that he/she be re-certified as an EMT.
- I recommend that he/she **not** be re-certified as an EMT.

Printed Name of Physician or Qualified Instructor

Signature of Physician or Qualified Instructor (Sign in BLUE ink)

7. **CHILD SUPPORT INFORMATION:** (License cannot be issued unless the applicant provides the following information.)

Please check one of the following:

- I am not subject to a court order for the support of a child.
- I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the District Attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or
- I am subject to a court order for the support of one or more children and am not in compliance with the order or a plan approved by the District Attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

8. **SERVICE REVIEW:** (License cannot be issued unless the applicant obtains a signature from both the Service EMS Coordinator and Service Medical Director.)

I have reviewed this application and I approve of the applicant being issued an ambulance attendant license by the Nevada State Health Division.

Service EMS Coordinator: _____ Date: _____
Signature (Sign in BLUE ink)

Service Medical Director: _____ Date: _____
Signature (Sign in BLUE ink)

9. **CERTIFICATION OF APPLICANT:**

I hereby certify that all statements made in this application are true and understand that any misstatement of material facts may cause forfeiture on my part of all rights to licensure by the State of Nevada as an ambulance attendant. In addition, I understand that my fingerprints may be forwarded to the Federal Bureau of Investigation as part of the background check conducted by the Health Division and hereby authorize such action by the Health Division.

Applicant: _____ Date: _____
Signature (Sign in BLUE ink)

**ANY MISREPRESENTATION OR OMISSION MAY RESULT IN FORFEITURE
OR DENIAL OF LICENSE**

Nevada State EMS Office
4150 Technology Way, Suite 101
Carson City, NV 89706
(775) 687-7590