



Emergency Medical Services Agency

1340 Arnold Drive, Suite 126
Martinez, CA 94553
(925) 646-4690 Fax: (925) 646-4379

PARAMEDIC Re-ACCREDITATION / MICN Re-AUTHORIZATION

___ Paramedic

___ MICN

Name _____		Date of birth ____/____/____	
Mailing address _____	City _____	State ____	Zip _____
California Drivers License # _____	Phone _____	Cell phone _____	
License # _____	Expiration date _____	SS# _____	
Employer _____	Email _____		

Are you currently authorized/accredited in any other California County? YES NO

If yes, list all counties and/or any other state(s) in which you have ever been authorized/accredited, starting with most current:

DATES	COUNTY OR STATE (ATTACH SEPARATE SHEET IF NECESSARY)
_____	_____
_____	_____
_____	_____

Have you ever had an authorization/accreditation denied, suspended, revoked, or are you involved in a formal investigation at this time? Yes No If yes, explain _____

Have you ever been convicted of any crime (other than a minor traffic violation)? Yes No If yes, explain _____

Is your authorization/accreditation currently on probation? Yes No If yes, explain _____

I certify that all information on this application is true and correct to the best of my knowledge and belief. I understand all information on this application is subject to verification. I hereby give my express permission for the EMS Agency to contact my employer, previous employer(s), prospective employer and authorizing/accrediting agency(ies) for information related to my position and/or authorization/accreditation. I further authorize the release of information by my employer and/or the accrediting agency which is relative to my role and function as a Paramedic/MICN in California.

SIGNATURE OF APPLICANT: _____ **DATE:** _____

ATTACHMENTS	
<u>PARAMEDIC</u> ___ Copy of State License ___ Copy of ACLS ___ Verification of skills competency	<u>MICN</u> ___ Copy of RN License ___ Copy of ACLS card (front & back) ___ Documentation of CE