EMERGENCY MEDICAL TECHNICIAN (EMT) CERTIFICATE APPLICATION

MARIN COUNTY EMS AGENCY
1600 Los Gamos Dr. #220, San Rafael, CA 94903
ph. 415-473-6871 fax 415-473-3747
www.MarinEMS.org

You must apply in person at the EMS office with a valid photo ID. All new applicants must complete a fingerprint live scan (DOJ background check**).** The form for the live scan is available at the EMS office and online at www.MarinEMS.org *Incomplete applications will not be accepted.* Fees are non-refundable.

Last Name	First Name	Middle Initial
Residence Address	Mailing Address if different than residence address	

City	State	Zip	City	State	Zip

Phone	Date of Birth	Social Security Number

E-mail	Age	Gender
		☐ Female ☐ Male ☐ Nonbinary

Ethnicity/Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ White

If employed by an EMS Provider(s) list here:

Primary Employer	Other Employer

Have you ever been convicted of any felony or misdemeanor offense in California or in any other state or place, including entering a plea of nolo contendere or no contest, including any conviction which has been expunged (set aside) under Penal Code Section 1203.4? ☐ Yes ☐ No

Are there any criminal charges currently pending against you? ☐ Yes ☐ No

If yes to either of these questions, attach a detailed statement describing the crime(s), date, location, court, sentence served, and parole, if any. You must also attach any applicable court documents and police reports.

Have you ever had a certification, accreditation, or professional healing arts license denied, suspended, revoked or placed on probation, or are you under investigation at this time? ☐ Yes ☐ No

If yes, you must enclose with this application a written explanation that describes the action, any corrective action, and/or remediation as a result of the action.

I hereby certify under **penalty of perjury** that all information on this application is true and correct to the best of my knowledge and belief, and I understand that any falsification or omission of material facts may cause forfeiture on my part of all rights to EMT certification in the state of California. I understand all information on this application is subject to verification, and I hereby give my express permission for this certifying entity to contact any person or agency for information related to my role and function as an EMT in California.

Signature: _____ **Date:** _____

Office Use Only	
☐ Completed and signed application form Date _____	☐ DOJ Date _____ Initials _____
☐ ID Initials _____	ATI # :
☐ Healthcare provider CPR card (or equivalent)	☐ Approved Date _____ Initials _____
☐ National Registry EMT certificate & wallet card	☐ Registry Date _____ Initials _____
☐ $90 Fee paid by: ___CC ___CHK ___CSH ___Invoice	☐ Card Issued Date _____ Initials _____
Receipt #_____	