



# EMERGENCY MEDICAL TECHNICIAN (EMT) CERTIFICATE RENEWAL

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

*Incomplete applications will not be accepted.* Applicants changing certifying entity 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](http://www.MarinEMS.org)  
Fees are non-refundable.  Change of Certifying Entity

Last Name			First Name			Middle Initial					
Residence Address <input type="checkbox"/> Change?						Mailing Address if different than residence address					
City		State		Zip		City		State		Zip	
Phone				Date of Birth				Social Security Number			
E-mail								Gender <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary			
Ethnicity/Race <input type="checkbox"/> American Indian or Alaska Native				<input type="checkbox"/> Asian				<input type="checkbox"/> Black or African American			
<input type="checkbox"/> Hispanic or Latino				<input type="checkbox"/> Native Hawaiian or Other Pacific Islander				<input type="checkbox"/> White			
Current Certification Number				Certification Expires				Age			
<b>If employed by an EMS Provider(s) list here:</b>											
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.

If the above "yes" items have been previously disclosed with no changes and are on file with the EMS Agency check box:

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

<input type="checkbox"/> Completed and signed application form Date _____ <input type="checkbox"/> ID Initials _____ <input type="checkbox"/> Healthcare provider CPR card (or equivalent) <input type="checkbox"/> Skills verification form <input type="checkbox"/> Proof of training: naloxone, epinephrine, glucometer <input type="checkbox"/> Appropriate number of CE hours ( <input type="checkbox"/> 24 <input type="checkbox"/> 36 <input type="checkbox"/> 48) <input type="checkbox"/> Fees paid by: ___CC ___CHK ___CSH ___Invoice ___\$52 ___\$90 Receipt # _____	<input type="checkbox"/> DOJ Date _____ Initials _____ ATI # : _____ New Exp. Date: _____ <input type="checkbox"/> Approved Date _____ Initials _____ <input type="checkbox"/> Registry Date _____ Initials _____ <input type="checkbox"/> Card Issued Date _____ Initials _____
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