Washington State Department of
HEALTH

EMS Portability of Professional Licenses of Members of the Uniformed Services and Their Spouses Application Packet

Contents:

1. 530-254...... Contents List/ Mailing Information .... 1 page
2. 530-255...... Application Instructions Checklist... 2 pages
3. 530-256...... EMS Portability of Professional Licenses of Members of the...............
   Uniformed Services and Their Spouses Application Packet.................................... 2 pages
4. 530-117...... General Instructions Checklist and EMS Supervisor/Medical
   Program Director Signature Form.. 2 pages
5. RCW/WAC and Online Website Links .... 1 page

In order to process your request:

Send completed application and other documents to:

Department of Health
EMS Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

(This page intentionally left blank)

Washington State Department of HEALTH

Application Instructions Checklist

This application is submitted under Public Law No. 117-333 Section 19. You must hold an active Emergency Medical Services License in another state that is in good standing and in compliance with continuing education requirements (if applicable).

☐ **1. Demographic Information:**

Legal Name: List your full name: first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name.

Birth date: Provide the month, day, and year of your birth.

Address: List the address we should use to send any information about your credential. Be sure to include the city, state, zip code, county, and country. This will be your permanent record with Department of Health until we have been notified of a change.

Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers.

Email: Enter your email address, if you have one. We will use the email address provided as the primary contact source to update you on the status of your application. It is important to ensure your email address is correct and current at all times.

☐ **2. Disciplinary Action Attestation: Required to be both initialed and dated to process the application.**

☐ **3. Other License, Certification, or Registration:**
List all states, including Washington, where active credentials are held. Attach additional pages if you need more space.

☐ **4. Applicant's Attestation:**
You must print your name and read the statement thoroughly to ensure you understand the provisions in this section. Provide the date and city you are in, then sign the statement. This must be complete in order for us to process your application.

Agency Association

Completion of the EMS Supervisor/Medical Program Director Signature Form which shows proof of EMS Agency association and includes recommendation by the county medical program director. Your license will be inoperable until the Supervisor/Medical Program Director Signature Form is submitted.

Note: You cannot practice as an emergency medical services provider until you have EMS association.

Documents to submit with your application should include the following:

- A copy of your military orders

  OR

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State; and
- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

Additional Information:

You will be mailed or emailed a letter regarding any additional information needed.

Washington State Department of HEALTH

Date Stamp Here

EMS Portability of Professional Licenses of Members of the Uniformed Services and Their Spouses Application

Certification Level: ☐ EMR ☐ EMT ☐ AEMT ☐ Paramedic ☐ Poison Control Specialist

1. Demographic Information

Social Security Number (SSN)				☐ Male ☐ X ☐ Female ☐ Prefer Not to Answer
Name	First		Middle	Last
Birth date (mm/dd/yyyy)				
Address				
City		State	Zip Code	County
Country				
Phone (enter 10 digit #)	Fax (enter 10 digit #)			Cell (enter 10 digit #)
Email address				
Mailing address (if different from above)				
City		State	Zip Code	County
Country				

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No

If yes, list name(s):

2. Disciplinary Action Attestation

I certify no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

I am subject to the jurisdiction of the state of Washington and the disciplining authority for my profession under RCW 18.130.040 and that Washington's Uniform Disciplinary Act, chapter 18.130 RCW applies to my practice, including enforcing standards of practice, unprofessional conduct, discipline, and continuing education.

Unless I obtain appropriate licensure in Washington, I must maintain my licenses issued by other states in good standing in order to continue practicing in Washington State.

Applicant's Initials	Date

3. Other License, Certification or Registration

List all states, including Washington, where active credentials are held. Attach additional pages if you need more space.

State	Profession	License Type	License		Method of License	Currently in Force
			YR issued	Number		
						☐ No ☐ Yes
						☐ No ☐ Yes
						☐ No ☐ Yes

4. Applicant Attestation

I, ______________________________, declare under penalty of perjury under the laws of the state of
(Name of Applicant)

Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read RCW 18.130.170 and RCW 18.130.180 of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

Dated ____________________________ By: ____
(mm/dd/yyyy) (Signature of Applicant)

Washington State Department of HEALTH

General Instructions Checklist EMS Supervisor/Medical Program Director Signature Form

The EMS Supervisor/Medical Program Director Signature form is required for each of the following applications:

- Initial EMS Certification Application
- EMS Out-of-State Reciprocity/Challenge Application
- Recertification Application

☐ **1. Identification Information:**

Fill in your Department of Health credential number, telephone number, date of birth, name, and address. Your credential number can be found at Provider Credential Search.

☐ **2. EMS Agency Association Requirement and EMS Supervisor:**

To be certified you must be associated with an EMS agency licensed by the Washington State Department of Health. Your EMS agency supervisor must complete this portion of the form.

Note: You cannot sign for yourself as supervisor. Please have your supervisor sign and date the form.

☐ **3. County Medical Program Director (MPD):**

Follow the instructions from your local EMS coordinator or EMS agency supervisor to obtain your MPD's recommendation, signature and date. Your application is not complete until it is signed and dated by the MPD recommending you for certification.

Additional Information:

The EMS application process requires both this signature form and the appropriate Certification Application Packet.

Washington State Department of HEALTH

EMS Supervisor/Medical Program Director Signature Form

Check Appropriate Box:

☐ Initial ☐ Upgrade ☐ Reversion ☐ Reciprocity

☐ Challenge ☐ Recertification ☐ Reissuance ☐ Reinstatement ☐ Portable License

Certification Level (check one): ☐ EMR ☐ EMT ☐ AEMT ☐ Paramedic ☐ Poison Information Specialist

1. Identification Information

Name First	Middle	Last

Birthdate (mm/dd/yyyy)	Phone (enter 10 digit #)	Email Address:

Address

City	State	Zip Code	County

2. EMS Agency Association Requirement and EMS Supervisor

Please provide the following information regarding your primary agency association:

Agency Name	Agency Credential Number

Address

City	State	Zip Code

Phone (enter 10 digit #)

Contact Person Name	Contact Person Email

"I affirm that if this applicant is certified, he/she will provide care with our EMS agency."

Printed Name of EMS Agency Supervisor | Original Signature | Date

3. County Medical Program Director (MPD)

The signature of the Washington State Medical Program Director (MPD) for the county where the applicant is providing care, or where his/her EMS agency is based, is required before state certification may be granted to this applicant.

☐ "I recommend certification of this applicant based on the statements above, and the successful completion of the required examinations and/or evaluations. This applicant, if recommended for certification, has a copy of my county protocols."

Protocol requirements do not apply to poison information specialists.

☐ I do not recommend certification (attach a memo for details)

Printed Name of County MPD | Original Signature | Date

Washington State Department of HEALTH

RCW/WAC and Online Website Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Emergency Medical Services and Trauma Care Systems, WAC 246-976

Emergency Medical Services Evaluator Requirements, WAC 246-976-163

Public Law No. 117-333 Section 19

Online

Emergency Medical Services Web Page