**Application for Initial NREMT Testing Voucher Program**

***To be completed by EMS Service or course SEI***

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| **Request and Application Contact Information** |
| Level of initial EMS test voucher(s) requested (EMR, EMT, AEMT):  |
| Number of voucher(s) requested:  |
| **Requestors Information:**  | Name:Title:  | Phone Number: Email:  |

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| **Course Information** |
| Course credential number:(Example: TRNG.ES.XXXXXX-Course) |   |
| Course number:(Example: I17-XX-XXX) |   |
| Estimated course completion date: |   |
| **Course SEI** | Name: Phone/Email:  |

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| **General Student Questions** |
| **Student Name** | **Agency Affiliation** | **Who paid for the course fee?*****EMS Service or Individual*** | **Who is responsible for the exam fee?*****EMS Service or Individual*** | **If the fee is paid by student, are they reimbursed?*****Yes or No*** |
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If multiple services are represented by the student group above, please identify the information for each service below.

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| **EMS Service Affiliation Information**  |
| EMS Service Name:  | Phone Number:  |
| County: Region:  |  |
| Legacy # or FDID:  | Email:  |
| **Based on the last EMS Service Licensure Application:** | What is your EMS service staffing model? | [ ]  Paid [ ]  Volunteer [ ]  Combination |
| Is the EMS service using non-medically trained drivers? | [ ]  Yes [ ]  No |
| Is the EMS service using Advanced First Aid (AFA) personnel? | [ ]  Yes [ ]  No |
| **EMS Service Affiliation Information**  |
| EMS Service Name:  | Phone Number:  |
| County: Region: |  |
| Legacy # or FDID:  | Email:  |
| **Based on the last EMS Service Licensure Application:** | What is your EMS service staffing model? | [ ]  Paid [ ]  Volunteer [ ]  Combination |
| Is the EMS service using non-medically trained drivers? | [ ]  Yes [ ]  No |
| Is the EMS service using Advanced First Aid (AFA) personnel? | [ ]  Yes [ ]  No |
| **EMS Service Affiliation Information**  |
| EMS Service Name:  | Phone Number:  |
| County: Region:  |  |
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| **Based on the last EMS Service Licensure Application:** | What is your EMS service staffing model? | [ ]  Paid [ ]  Volunteer [ ]  Combination |
| Is the EMS service using non-medically trained drivers? | [ ]  Yes [ ]  No |
| Is the EMS service using Advanced First Aid (AFA) personnel? | [ ]  Yes [ ]  No |

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| **Attestation of Information** |
|  [ ]  I hereby affirm and declare that the information provided on this application is true and correct.Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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 doh.information@doh.wa.gov.