Application for Initial NREMT Testing Voucher Program

To be completed by EMS Service or course SEI

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:

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:

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***

Please return to Washington State DOH Emergency Care System three weeks before the end of your course.

Washington State Department of Health, Emergency Care System,

Email: hsqa.ems@doh.wa.gov

With Questions Contact: Dawn Felt 360-236-2842 or Jill Hayes 360-236-2838

If multiple services are represented by the student group above, please identify the information for each service below.

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:		
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

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.