



EMS Responder Application		OFFICE USE ONLY	
Submit Completed Form(s) and Payment to:		Payment Rec'd	\$
Mail	KBEMS	Ck#	
	Attn: Education	Date Certified	
	300 North Main St.	Certification #	
	Versailles, KY 40383	Expiration	

**Application Type**

Please check the level of certification along with the type of application you are applying for. (i.e. If you are applying to renew your paramedic license, you will select the box under renewal and across from Paramedic).

	Initial	Renewal	Reinstatement	Reciprocity	Temporary
EMR- First Responder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Medical Technician (EMT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advanced Emergency Medical Technician (AEMT)	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A	N/A
Paramedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please select if you are a Paramedic applying for Critical Care Endorsement (If not, leave Blank)

Critical Care Endorsement	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A	N/A
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If you are applying for your Instructor Certification or Evaluator endorsement, please indicate below. Please select only the highest level you are applying for. If not, leave blank.

	Initial	Renewal		Initial	Renewal
Instructor Level I	<input type="checkbox"/>	<input type="checkbox"/>	Evaluator Level I	<input type="checkbox"/>	<input type="checkbox"/>
Instructor Level II	<input type="checkbox"/>	<input type="checkbox"/>	Evaluator Level II	<input type="checkbox"/>	<input type="checkbox"/>
Instructor Level III	<input type="checkbox"/>	<input type="checkbox"/>	Evaluator Level III	<input type="checkbox"/>	<input type="checkbox"/>

**Current Certifications**

Please list any current certifications numbers you currently have and the state in which they were issued.

	Number	State	Exp. Date		Number	State	Exp. Date
National Registry		N/A		Advanced EMT (AEMT)			
First Responder /EMR				Paramedic			
EMT							

**Applicant Information**

First Name		Middle		Last		Suffix		
Address							Apt#	
City			State		Zip			
Home #			Mobile #		County			
Email			Maiden Name					
Social Security #			Birth Date		Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Drivers License #			Driver's License Expiration		Driver's License State			

**Education \*Mark highest level completed**

High School
  GED
  Some College
  College Degree
  Masters
  PhD

**EMS / Fire Dept. Agency Information \*Please complete if affiliated with an agency. Attach additional sheets if necessary.**

Agency		Status	<input type="checkbox"/> Career/Paid	<input type="checkbox"/> Volunteer
Address				
City		State		Zip
Phone	Fax	County		License #
Agency		Status	<input type="checkbox"/> Career/Paid	<input type="checkbox"/> Volunteer
Address				
City		State		Zip
Phone	Fax	County		License #
Agency		Status	<input type="checkbox"/> Career/Paid	<input type="checkbox"/> Volunteer
Address				
City		State		Zip
Phone	Fax	County		License #



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**Initial or Reciprocity Applicants Only:**

Course Number		Educational Institution	
Course Coordinator		Phone	
Course Location		Completion Date	

If you are seeking reciprocity, you must provide proof of certification in another state. (EMR/First Responders and EMTs Only)

**Please Answer the Following Questions:**

NOTICE: All questions on this application must be answered. Failure to respond to these questions will result in the application being returned as incomplete. If you answer 'Yes' to any of the questions below you must attach an explanation on a separate sheet including copies of court documents, disciplinary actions, or physician's statement, if applicable.

1. Have you ever been convicted of a felony, pled guilty to a felony, entered into an Alford plea to a felony, or participated in a diversion program for a felony?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
2. Have you ever been convicted of a misdemeanor?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
3. Have you ever been convicted of Driving Under the Influence (DUI)?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
4. Have you ever been cited for a moving violation while operating an emergency medical vehicle?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
5. Have you ever had a civil judgment entered against you arising from a situation(s) in which you were delivering or attempting to deliver medical care?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
6. Have you ever been in default on any student loans?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
7. Have you at any time had your certification(s) or registration(s) as a EMR/First Responder, EMT, Advanced-EMT, Paramedic, Registered Nurse, Physician or its equivalent, been restricted, revoked, denied, suspended, or expired in the Commonwealth of Kentucky or another state?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
8. Have you at any time had any instructor certification restricted, revoked, denied, suspended, or expired?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
9. Are you currently under disciplinary action with KBEMS?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
10. If you have marked 'Yes' to any of the above questions #1-9, have you reported this to the KBEMS office?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
11. Do you have the ability to understand, read, speak, and write the English language with a comprehension and performance level equal to at least the ninth grade of education, otherwise known as level 4, verified by testing as necessary?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

**American with Disabilities Act (ADA) Notification:**

If you have a physical, mental, or other disability which might entitle you to receive restricted certification or license in education or employment you must supply medical records or documentation thereof to receive reasonable accommodation.

**Applicant Declaration**

I hereby certify that the information provided on this application is complete and true. I understand that knowingly supplying false information on this application is a violation of KRS Chapter 311A and subjects me to the full range of disciplinary action described therein. I further understand that my application can be returned to me incomplete if I failed to provide all information requested on this application.

Signature of Applicant	Date
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### FOR RENEWAL APPLICANTS ONLY

Continuing Education – Please complete either Section I or Section II whichever applies (DO NOT COMPLETE BOTH SECTIONS)

**Section I: Complete if your service/organization/department retains your continuing education documents.**

I hereby certify that the applicant has successfully completed, the two (2) year Certification/Licensure period continuing education as required by 202 KAR 7:201, 202 KAR 7:301, 202 KAR 7:401, and/or 202 KAR 7:601.

I further validate that documentation of these continuing education hours will be maintained by the undersigned and furnished to the Kentucky Board of Emergency Medical Services upon request.

Medical Director, Instructor, Training Officer, or Service Provider Signature	Date
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Printed Name	Title
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I hereby certify that I have completed the continuing educational requirements for my two (2) year licensure/certification period required by 202 KAR 7:201, 202 KAR 7:301, 202 KAR 7:401, and/or 202 KAR 7:601 and that the information provided on this application is complete and true to the best of my knowledge. I understand that knowingly supplying false information on this application is a violation of KRS Chapter 311A and subjects me to the full range of disciplinary action described therein. I also understand that my application can be returned to me incomplete if I failed to provide all information requested on this application. I further affirm that documentation of my continuing education hours shall be furnished to the Kentucky Board of Emergency Medical Services upon request.

Applicant Signature	Date
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**Section II: Complete if you retain your continuing education documents.**

I hereby certify I have completed the continuing educational requirements for my two (2) year Certification/Licensure period required by 202 KAR 7:201, 202 KAR 7:301, 202 KAR 7:401, and/or 202 KAR 7:601 and that the information provided on this application is complete and true to the best of my knowledge. I understand that knowingly supplying false information on this application is a violation of KRS Chapter 311A and subjects me to the full range of disciplinary action described therein. I further affirm that documentation of my continuing education hours shall be furnished to the Kentucky Board of Emergency Medical Services upon request. I also understand that my application can be returned to me incomplete if I failed to provide all information requested on this application.

Applicant Signature	Date
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Notice: All return checks shall be subject to a processing charge in the amount of Twenty Five Dollars (\$25.00). In addition, any applicant or licensee issuing a check which is returned shall be deemed to have violated KRS 311A.050 (2) (a). That person shall be sanctioned which may result in a fine, suspension, or license revocation.