EMS Agency Credentialing Form

EMS Agency: ______________________________ Calendar Year: __________

ALS Practitioner: ____
Last Name First Name

Address: ______________________________ Apt# ________

City: ____________________ State: ________ Zip: ______________

Email: ____

Certification Level: ☐ AEMT ☐ Paramedic ☐ PHRN ☐ PHPE ☐ PHP ☐ ALS Student

Certification Number: ______________ Expiration: ____ / ____ / ____ (MM DD YYYY) CPR Exp: ____ / ____ (MM YYYY)

Credentialing: ☐ Initial with this agency ☐ Annual Review

Decision Rendered: ☐ Unrestricted practice within certification level
☐ Restricted for precepting (For initial credentialing)
☐ Restricted practice-Enrolled in a Accredited ALS training program
☐ Restricted practice (See restrictions below)

Restrictions:

As the EMS agency medical director of the referenced EMS agency, I have evaluated the individual's qualifications based upon the individual's ability to competently perform each of the services set forth within the scope of practice authorized by the individual's certification.

______________________ ______________________ ___/___/___
Agency Medical Director (Print) Agency Medical Director (Signature) Date

______________________ ______________________ ___/___/___
Operational Officer (print) Operational Officer (Signature) Date

____ ___/___/___
ALS Practitioner Signature Date