Emergency Medical Services Subcommittee Application Form

Date: _____ Name: _____

E-mail:_____ Phone: _____

Address/City/State:_____

_____

Organization or Employer:_____

Check all that apply:

EMT	□	Certification #_____	Expiration Date _____
AEMT	□	Certification #_____	Expiration Date _____
EMT-IA	□	Certification #_____	Expiration Date _____
Paramedic	□	Certification #_____	Expiration Date _____
EMD	□	Certification #_____	Expiration Date _____
EMS Instructor	□	Certification #_____	Expiration Date _____
Training Officer	□	Certification #_____	Expiration Date _____
Course Coordinator	□	Certification #_____	Expiration Date _____
Registered Nurse	□	Years of EMS experience _____	
Medical Doctor	□	Years of EMS experience _____	
Medical Control Doctor	□	Affiliated EMS Agency_____	
Other	□	Description_____	

Please describe your experience related to Emergency Medical Services:

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_____

Reference #1_____
Name Phone Email Relation

Reference #2_____
Name Phone Email Relation

Please send completed application to:

jlehman@utah.gov

or mail:

Bureau of Emergency Medical Services and Preparedness

Attention - Jenny Lehman

PO BOX 142004

Salt Lake City UT 84114