NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

Verification of Membership in a NYS EMS Agency

Please print legibly in capital letters or type. Put one letter or number in each box.
This form must be completed and returned to the Course Sponsor prior to the completion of the course.

Course Number | | | | | | | **(Please retain this number for future reference)**

Check if this application is for: ☐ **Original Certification** ☐ **Recertification** **(If you are recertifying you must include your NYS EMS I.D. Number)**

EMS Identification Number (If you have one)
Only write your NYS EMS number in this space

Applicant's Last Name

Applicant's First Name and M.I.

Last 4 Of Your Social Security Number

X X X X X | | | | |

Date of Birth Month | | Day | | Year | |

If you belong to an EMS agency, please indicate the agency code in the box(es) below.

Primary EMS Agency

Secondary EMS Agency

Primary Agency Name

Primary Agency Captain, Chief, or other agency official signing the affirmation on this form

Last Name

First Name and M.I.

NYS EMS Identification Number (If you have one)

Official's Agency Title

Personal Affirmation **Read Carefully Before Signing**

I, as an official representative of the primary NYS EMS agency listed on this form, affirm that the applicant named on this form is a member of the primary NYS EMS service. I further understand that offering or providing false information on this document may constitute a crime under the penal law and may subject any certification to revocation or other Department action.

I, as the applicant, hereby certify that all of the information contained in this application is true and correct and that the signature below is mine as applicant. I further understand that offering or providing false information on this document may constitute a crime under the penal law and may subject any certification to revocation or other Department action.

(Agency Official's Signature) **(Date)**

(Applicant's Signature) **(Date)**