

DEPARTMENT OF HUMAN SERVICES
EMERGENCY MEDICAL SERVICES AND TRAUMA SYSTEMS
800 NE Oregon Street, Suite 465
PORTLAND OR 97232-0450
971-673-0526
<http://egov.oregon.gov/DHS/ph/ems/certific/recert.shtml>

AGENCY EMT RECERTIFICATION FORM

Agency Name: _____
(print)

Agency Number (four-digit DHS/EMS Code): _____

Please list in alphabetical order all EMT recertification applications that are enclosed on the reverse side of this page. NOTE: An alphabetized computer generated list may be attached to this signed roster in lieu of listing the personnel on this roster, if the computer list contains all required information.

I certify that I am the medical director of the herein named applicants for recertification as an Emergency Medical Technician (EMT). I have reviewed these applications and I am aware of no physical, mental, or legal impairment which would preclude the applicants from being recertified as an EMT. I further certify that these applicants are in possession of signed standing orders from me, and to the best of my knowledge is clinically competent to perform at the level for which recertification is requested.

Medical Director: _____
(Print)

Medical Director: _____
(Signature)

Date: ____/____/____

I certify that I am the Chief Officer or authorized designee of the primary EMS agency listed by the applicants making these applications for recertification. I have reviewed these applications and I am aware of no physical, mental, or legal impairment which would preclude this applicant from being recertified as an EMT. I further certify that I have reviewed the applicant's record of continuing education and skills proficiency demonstration, where applicable, and that this record reflects that the applicant meets the requirements for recertification prescribed by the DHS/EMS.

EMS Agency Chief Officer: _____
(Print)

EMS Agency Chief Officer: _____
(Signature)

Date: ____/____/____

Phone: _____ e-mail _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

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