PARAMEDIC INITIAL / RE-ACCREDITATION / TRANSFER APPLICATION FORM

INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED
PLEASE ATTACH COPIES TO YOUR APPLICATION
APPLICATION PROCESSING TIME IS 15 BUSINESS DAYS

Initial Application must include a copy of a current:

- ☐ Completed EMT-P application,verification of employment by an approved San Francisco (SF) ALS provider, orientation to EMS system, and field evaluation.
- ☐ State of California Paramedic License
- ☐ California Driver's License
- ☐ ACLS Card
- ☐ PALS, PEPP or EPC Card
- ☐ PHTLS or ITLS Card
- ☐ Healthcare Provider CPR Card
- ☐ Payment of $32.00 to the City and County of San Francisco via check/money order, over-the-counter debit/credit card, or on-line credit card

Re-Accreditation Applications must include a copy of a current:

- ☐ Completed application and verification of employment by an SF ALS Provider
- ☐ San Francisco EMT-P Accreditation Card
- ☐ New State of California Paramedic License
- ☐ California Driver's License
- ☐ ACLS Card
- ☐ PALS, PEPP or EPC Card
- ☐ Healthcare Provider CPR Card
- ☐ Payment of $32.00 to the City and County of San Francisco via check/money order, over-the-counter debit/credit card, or on-line credit card **IF ACCREDITATION HAS LAPSED**

Transfer of Accreditation to Another ALS Employer:

- ☐ Complete application and verification of employment by SF ALS Provider

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CHECK ONE: ◯ INITIAL ◯ RE-ACCREDITATION ◯ TRANSFER

San Francisco EMT-P Accreditation #_____ California State EMT–P License # _____

Last Name _____ **First Name** _____ **MI** _____

Address _____

City _____ State _____ Zip _____

Birthdate _____/_____/_____ Social Security # _____ - _____ - _____

Cell Phone # ( ) _____ - _____ E-Mail Address _____

Drivers License #_____ Current Employer _____

ANSWER THE FOLLOWING QUESTIONS BEFORE SIGNING THE APPLICATION:

◯ **yes** ◯ **no** **Have you ever had a certification, accreditation, or professional license denied, suspended, revoked, placed on probation, or are you under investigation at this time?**

◯ **yes** ◯ **no** **Are there criminal charges pending against you?**

◯ **yes** ◯ **no** **Have you ever been convicted of any felony or misdemeanor offense in California or in any other State or place, including entering a plea of nolo contendere or no contest, and including any conviction which has been expunged (set aside) under Penal Code Section 1203.4?**

If you answered **Yes** to any of the above questions, attach a written explanation describing the crime, date, location, court, conviction, corrective action, and/or remediation. Attach DMV, court, and police records.

I hereby certify under penalty of perjury that all information on this application is true and correct to the best of my knowledge and belief. I understand any falsification or omission of material facts may cause forfeiture on my part of all rights to EMT-P Accreditation in the City and County of San Francisco. I understand all information on this application is subject to verification, and I hereby give my express permission for this certifying entity to contact any person or agency for information related to my role and function as an EMT-P in California.

Signature _____ Date _____

Attach required documents to the application and e-mail, mail, or bring into the office at:

San Francisco EMS Agency
Attn: Accreditation
30 Van Ness Avenue, Suite 3300
San Francisco, CA 94102-6027

FOR EMSA USE ONLY:

Application Received in Person on _____ by _____ Application Received by Mail on _____

SF EMT-P Accreditation # _____Issue Date_____ Expiration Date_____

ACLS Expiration Date _____ PALS/PEPP/EPC Expiration Date _____

PHTLS/ITLS Expiration Date _____ CPR Expiration Date _____

Initial/Lapsed Accreditation Payment of $32.00 can be paid by:
Check/Money Order $_____
OTC Debit/Credit Card $_____
On-Line Credit Card $_____

THIS FORM TO BE COMPLETED BY THE ALS PROVIDER

INITIAL EMT-P ACCREDITATION APPLICANTS

1. Enter initials for the authorized provider below to verify that candidate has successfully completed:

_____ Provider orientation to the SF EMS system, EMSA Policies and Protocols and SF geography
_____ 10 ALS patient contacts with a Field Training Officer, with competency evaluation
_____ ICS 100 and 200, IS 700a, and Hazmat First Responder Awareness Course
_____ Training and testing in SF Optional Scope of Practice

2. If candidate is employed by an ALS Provider with less than 1 year of service in SF, attach verification from previous employers that candidate has 2 years of ALS emergency response experience in the last 3 years.

☐ Documentation attached or ☐ Not applicable

3. This is to verify that the candidate meets all requirements and to recommend accreditation:

ALS Provider Name _____

ALS Provider Authorization _____ Title _____ Date _____
Signature

ALS Provider Authorization _____
Print Name

Upon return receipt from the EMS Agency, this form with any/all attachments will be kept on file with the above named ALS Provider Agency through the duration of the applicant's employment. Accreditation must be renewed concurrent with the State of California Paramedic License.

EMT-P RENEWAL ACCREDITATION APPLICANTS

ALS Provider has the following current documents on file for the applicant:

☐ Proof of completion of training on EMS Agency policy and protocol revisions that have been issued in the previous 24 months and are currently in effect

☐ Verification of completion of training as required by the San Francisco EMS Agency Medical Director as part of individual or system-wide quality improvement.

ALS Provider Name _____

ALS Provider Authorization _____ Title _____ Date _____
Signature

ALS Provider Authorization _____
Print Name

TRANSFER OF ACCREDITATION TO ANOTHER ALS EMPLOYER

Submit this application to the SF EMSA at least 2 business days in advance of assignment to the field.

Name of EMT-P _____ SF EMT-P Accreditation # _____
Previous Employer _____ Date released by employer _____
New Employer _____ Date of Hire _____

This individual has on file with new employer completion of training on EMS Agency policy and protocol revisions that have been issued in the previous 24 months and are currently in effect.

ALS Provider Authorization _____ Title _____ Date _____
Signature

ALS Provider Authorization _____
Print Name