THE NATIONAL REGISTRY OF EMERGENCY MEDICAL TECHNICIANS
Inactive to Active Request Form
Please Read Instructions

Registry Number

Social Security Number ___ – ___ – ____

Last Name

First Name

Mid. Init.

Mailing Address

City

State

Zip Code ____ – ____

E-mail

Phone Number ___ – ___ – ____

CRIMINAL CONVICTION STATEMENT

YES ☐ NO ☐ During your inactive period, were you convicted of a criminal conviction?

YES ☐ NO ☐ During your inactive period, were you subject to limitation, suspension from, or under revocation or probation of your right to practice in a health care occupation or voluntarily surrendered a health care licensure in any state or to any agency authorizing the legal right to work?

If you answered "yes" to either question, you must provide official documentation that fully describes the offense, current status and disposition of the case.

EMPLOYER CERTIFICATION

I certify that the applicant named above is presently working / or will be employed upon obtaining active status, with our agency:

_____
Authorized Agent Signature Date

_____
Printed Name of Authorized Agent

Agency: _____

Address: _____

City:_____ State: _____ Zip Code: _____

Daytime Phone Number: _____

SKILL COMPETENCY VERIFICATION	Direct Obs.	Other
1. PATIENT ASSESSMENT / MANAGEMENT: Medical and Trauma Patients		
2. VENTILATORY MANAGEMENT SKILLS / KNOWLEDGE: Adjuncts, Oxygen Delivery, Alternative Airways* Endotracheal Intubation*, Chest Decompression* / Cricothyrotomy*		
3. CARDIAC ARREST MANAGEMENT: AED, Megacode & EKG Recognition / Set-Up*, Therapeutic Modalities*		
4. HEMMORHAGE CONTROL & SPLINTING PROCEDURES		
5. IV THERAPY & IO THERAPY*: Medication Administration*		
6. SPINAL IMMOBILIZATION: Seated and Supine Patients		
7. OB/GYNECOLOGICAL SKILLS / KNOWLEDGE		
8. OTHER RELATED SKILLS / KNOWLEDGE: Radio Communications, Report Writing & Documentation		

As the Physician Medical Director of the above listed registrant, I do hereby affix my signature attesting the registrant has demonstrated sufficient competence to return to active status.

_____ _____ _____
*Physician Medical Director Signature (MD) (Training Officer may sign for EMT level ONLY) (must be original signature)
Title Position
Date Signed

* If applicable to your level or area

APPLICANT AFFIRMATION OF APPLICATION

I hereby affirm that all statements on this Inactive to Active Request Form are true and correct. I understand that any false or misleading statement(s) or documentation provided in part or in whole may be sufficient cause for revocation or denial of application or other actions by the NREMT. It is also understood that the NREMT may conduct and audit of the registration at any time.

_____ _____
Signature of Registrant (must be original signature)
Date

Office Use Only	
AS	AS
EC	EC
SC	SC
AAA	AAA
✔	✔

National Registry of
Emergency Medical Technicians®
THE NATION'S EMS CERTIFICATION™

Dear Nationally Certified EMS Professional:

The National Registry of EMTs is pleased to provide you with the necessary paperwork to facilitate your request to return your certification to active status. It is very important that you complete the Inactive to Active Request form in its entirety.

In order to process your request you must:

1. Complete all sections of the Inactive to Active Request form.
2. Obtain all required signatures where indicated.
3. E-mail the completed form to the NREMT at the address listed below.

E-mail documentation to:

InactiveToActive@NREMT.org

Please allow 4–6 weeks for your application to be processed. If you do not receive your updated National Certification card or your form is not returned within 6 weeks, you should call the recertification office at (614) 888-4484. It is certainly our pleasure to serve you and we look forward to your continued success in EMS.