inactive to active request form

Please Read Instructions

Reg No 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:

Agency: __________________________

Address: __________________________

Authorized Agent Signature Date

City: _______ State: _____ Zip Code: __________

Daytime Phone Number: __________________________

Printed Name of Authorized Agent

Skill Competency Verification

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. HEMORRHAGE 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)

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 Date

Signature of Registrant

Office Use Only

National Registry of EMTs • 6610 Busch Blvd • Columbus, OH 43229 www.nremt.org
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:

support@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.