Emergency Medical Services (EMS)
Evaluator Application Packet

Contents:

Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, please contact the Customer Service Center at 360-236-4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Send completed application and other documents to:

Department of Health
EMS Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

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Application Instructions Checklist

Thank you for your application for EMS Evaluator. All information should be printed clearly in blue or black ink. It is your responsibility to submit the required forms.

☐ **1. Demographic Information:**
Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360-236-4700 if you do not have one.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day and year of your birth.

Birth place: Provide the city, state and country where you were born.

Address: List the address we should use to send any information about your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with Department of Health until we have been notified of a change. See WAC 246-12-310.

Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See WAC 246-12-300.

☐ **2. Training Course Attestation—To be completed at renewal only:**
Sign this if you are not providing a certificate of completion.

☐ **3. Medical Program Director Attestation:**
Provide the printed name of your County Medical Program Director (MPD) and obtain their signature.

☐ **4. Applicant's Attestation:**
You must sign and date this for us to process the application.

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EMS Evaluator Requirements

Thank you for applying to become a EMS Evaluator in Washington State. To expedite the license process, please use the following checklist to ensure you have completed all requirements.

To apply to become a certified EMS Evaluator, applicants must:

- ☐ Complete an application on forms provided by the Department.
- ☐ Hold a current Washington State Certification at the EMT level or higher and have completed at least one three year certification cycle.
- ☐ Provide a certificate of completion as proof of an MPD approved EMS Evaluator Workshop specific to the level of certification being evaluated.

To renew an EMS Evaluator certification, applicants must:

- ☐ Complete an application on forms provided by the Department.
- ☐ Hold a current Washington State Certification at the EMT level or higher and have completed at least one three year certification cycle.

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Washington State Department of Health

Date Stamp Here

Emergency Medical Services (EMS) Evaluator Application

Please print clearly. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

Select One:
☐ Initial Certification ☐ Renewal

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)

☐ Male
☐ Female

Name First Middle Last

Birth date (mm/dd/yyyy)

Place of birth

City | State | Country

Address

City | State | Zip Code | County

Country

Phone (enter 10 digit #) | Fax (enter 10 digit #) | Cell (enter 10 digit #)

Email Address:

Mailing address (if different from above)

City | State | Zip Code | County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the Department of Health.

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No

If yes, list name(s):

2. Training Course Attestation (Renewal Applicants Only)

I certify that I have successfully completed a department and MPD approved ESE Evaluator Refresher Course.

Applicant's Initials	Date

3. Medical Program Director Attestation

I verify that the applicant has demonstrated proficiency in performing skills at the level of certification that the applicant will be evaluating and that the applicant is current in continuing education requirements for his/her primary certification.

☐ I recommend this applicant receive ESE Certification.

☐ I do not recommend this applicant receive ESE Certification.

Comments:

County Medical Program Director (MPD): _____ Date: _____
Print Name

MPD Original Signature _____

4. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of the
(Print applicant name clearly)
state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read RCW 18.130.170 and RCW 18.130.180 of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

By: _____ Dated _____
Signature of applicant

RCW/WAC and Online Website Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Emergency Medical Services and Trauma Care Systems, WAC 246-976

Emergency Medical Services Evaluator Requirements, WAC 246-976-163

On-line

AIDS Training Resources Reference Page

Emergency Medical Services Web Page