Emergency Medical Services Subcommittee Application Form

Date:		Name:		
-mail:	ail: Phone:			
Address/City/State:				
Organization or Emplo	oyer:			
Check all that appl	y:			
EMT		Certification #	Expiration Date	
AEMT		Certification #		
EMT-IA		Certification #		
Paramedic		Certification #		
EMD		Certification #		
EMS Instructor		Certification #		
Training Officer		Certification #		
Course Coordinator		Certification #		
Registered Nurse		Years of EMS experience		
Medical Doctor		Years of EMS experience		
Medical Control Docto	or 🗆	Affiliated EMS Agency		
Other		Description		
Reference #1		Phone	Email	Relatio
Reference #2				
Name		Phone	Email	Relatio
		application to:		
jschaugaard @utal	n.gov			
or mail:				
Bureau of Emerge	ncy M	edical Services and Prepare	edness	
Attention - Jess	ica S	Schaugaard		
PO BOX 142004				

Salt Lake City UT 84114