GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

Health Emergency Preparedness and Response Administration

Basic Life Support – Verification of Certification

This Section to be Completed by the Applicant

Applicant: Please complete the top portion of the form and submit it along with your application for certification.

Name: ____
Last *First* *Middle* *Other, if any*

Address: ____
Street *City* *State* *Zip*

Certification Level: ☐ EMR/First Responder ☐ EMT-Basic Certification #: ____________ Date Issued: ______________

I hereby authorize the ______________________________________ to furnish the District of Columbia Department of Health the information requested below.

Signature: ______________________________________ Date: ________________

This Section to be Completed by the Certification/Licensing Agency Only

The applicant listed above is applying for either an EMT-Basic or EMR/First Responder certification (as checked above) in the District of Columbia. Please provide the following information

This is to certify that the above named individual was issued a license or certification number ______________________ as an

☐ EMR/First Responder ☐ EMT-Basic Issue Date: ______________ Expiration Date: ______________

Current Status: ☐ Active ☐ Inactive ☐ Lapsed ☐ Other______________________________

What examination does your agency currently require for purposes of certification?
☐ National Registry ☐ State Board Examination ☐ Other______________________________

Has this individual completed a training program consistent with the US Department of Transportation Emergency Medical Responder/First Responder or EMT-Basic educational guidelines? **Yes** ☐ **No** ☐

If **No**, please provide a brief description of the requirements this individual completed for purposes of certification?

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Has the individual ever been subjected to disciplinary action of any type? **Yes** ☐ **No** ☐
If yes, please forward all publicly disclosable information regarding the disciplinary action and the individual's current status.

Signed: ______________________________________ Date: ______________

Name: ______________________________ Title: ______________________________

Daytime Phone: (______) ______________ E-Mail: ______________________________

Please complete and return directly to:
District of Columbia Department of Health
Health Emergency Preparedness and Response Administration
BLS Certifications
55 'M' Street, SE, Suite 300 Washington, DC 20003
By Fax: 671-0707