Lincoln County
Emergency Medical Services

Provider Verification Form

GENERAL INFORMATION

PLEASE PRINT

Last Name: _____ First Name: _____ MI: _____

Certification Number: _____ Badge #: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Pager: _____ E-Mail: _____

Organization: _____ Provider #: _____

Employee Status: [ ] Full-Time Paid [ ] Part-Time Paid [ ] Volunteer

Level of Application

All certifications MUST meet or exceed National DOT Guidelines
Please attach a copy of your certification or course completion notice. NO ORIGINALS

[ ] AED Responder [ ] EMT-Basic [ ] EMT-Paramedic

[ ] Medical Responder (MR) [ ] EMT-Intermediate [ ] EMD

Type of Application

[ ] Initial [ ] Recertification [ ] Upgrade [ ] Other: _____

Employee Signature: _____ **Date:** _____

Provider Affiliation Certification

This is to certify that the above named individual is affiliated on a continuous basis with the above named organization.

Signature of Ranking Officer: _____ **Date:** _____

Name & Title of Ranking Officer: _____

Skills/Performance Evaluation

This is to certify that the above named individual has successfully completed a skills/performance evaluation conducted under my direction and has demonstrated, to my satisfaction, his/her ability to perform skills and procedures consistent with the level of application.

Training Coordinator Signature: _____ **Date:** _____

Medical Director's Signature: _____ **Date:** _____

System Administrator's Signature: _____ **Date:** _____

ADMINISTRATIVE USE ONLY

DBE Signature: _____ **Date:** _____

EAF Signature: _____ **Date:** _____