NEW YORK STATE DEPARTMENT OF HEALTH Bureau of Emergency Medical Services

Verification of Membership in a NYS EMS Agency

Please print le														ourse) .
Course Number	ourse Number (Please retain this number for future reference)														
Check if this application is for:		Origina	I Cert	tificati	on [Rece	rtifica	tion				tifying SEMS I		
EMS I dentification Number (If you Only write your NYS EMS number in th		e)													
Applicant's Last Name															
Applicant's First Name and M.I.															
Social Security Number							Mon	th I	Day	Ye	ar				
				Date	of Bir	th									
If you belong to an EMS agency, p	lease indi	cate the	agen	cy code	in the	box	(es) b	elow.							
Primary EMS Agency	Second	dary EM	S Age	ncy											
Primary Agency Name															
Primary Agency Captain, Chief, or Last Name	other age	ncy offic	cial siç	gning t	he affi	rmat	ion or		NYS		denti			1	•
First Name and M.I.								r	umb	er (II	you h	nave (one)		
Official's Agency Title				<u> </u>				1		1	1	1			
Personal Affirmation I, as an official representative of the primary primary NYS EMS service. I further under under the penal law and may subject at I, as the applicant, hereby certify that a mine as applicant. I further understand law and may subject any certification to	stand that ny certifica all of the in I that offeri	offering of tion to re formation ng or pro	or provevocation contains	riding fa on or ot ained in false in	lse info her Der this app formation	rmatio partm plicati	on on tent action is t	ant name this docu tion. rue and	ed on thument	nis forr may o	constit	nembe ute a ne sig	r of the crime nature	below	
(Agency Official's Signature)								(Dat	e)						
(Applicant's Signature)								(Dat	e)						

DOH-3312 (1/03)