NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

Verification of NYS Certification

Please print legibly in capital letters or type. Put one letter or number in each box.

A letter of verification will be mailed to the address you provide on this form.

Requests for verification of certification must be submitted using this form.
No telephone requests will be accepted.

Allow 2-4 weeks for processing

EMS Identification Number
Only write your NYS EMS number in this space

Last Name

First Name and M.I.

Social Security Number

X X X X X

Date of Birth Month Day Year

Certified Provider's Mailing Street Address

Apartment Number

City

State

Zip Code

Name or address change since you last became certified:

Yes ☐ **No** ☐

If your letter of verification needs to be mailed to a different address than above, please provide the address and to whom's attention the letter should be sent to or the fax number we can fax your verification to:

Fax to: 518-402-0985 **or** **Mail to:** **NYS DOH BEMS Verifications**

Fax submissions preferred

(Certified Provider's Signature) **(Date)**