

**MONTANA BOARD OF MEDICAL EXAMINERS**

PO Box 200513

301 South Park Avenue 4th Floor

Helena, Montana 59620-0513

PHONE: 406-444-5711

FAX: 406-841-2305

E-MAIL: [dlibsmed@mt.gov](mailto:dlibsmed@mt.gov)

WEBSITE: [www.emt.mt.gov](http://www.emt.mt.gov)

**LICENSING REQUIREMENTS: EMERGENCY CARE PROVIDERS**

1. NREMT Certification, American Board of Pre-Hospital Care Board Certification or current license in another state in which you originally tested for licensure. The license must be at the level equal to or greater than the level of licensure you are applying for in Montana.
2. Possess a high school diploma or its equivalent (e.g., G.E.D)
3. 18 years old or older

**FEES:**

\$30.00 – EMR Emergency Medical Responder

\$50.00 – EMT Emergency Medical Technician

\$70.00 – AEMT Advanced Emergency Medical Technician

\$100.00 – Paramedic

*\*Make check or money order payable to the Montana Board of Medical Examiners\**

**DOCUMENTS:** The following documentation must be submitted for individuals who are applying for initial Licensure or reapplying for licensure.

1. Proof of High School diploma or its equivalent, such as a college transcript, GED, etc
2. Birth Certificate or other verifiable evidence of the applicant's date of birth, ie. driver's license
3. Current NREMT card or American Board of Pre-Hospital Care Board Certification or proof of state licensure equal to or greater than the level you are applying for in that state
4. If applying with state licensure (without NREMT or ABPC certification) you must submit proof that you took an NREMT-equivalent examination to obtain licensure in that state.
5. RESULTS of a current self-query on the National Practitioners Databank (letter unopened)

**The Following documentation must be submitted for individuals who have maintained continuous licensure in Montana as an EMT and are applying for another level.** Current NREMT card or American Board of Pre-Hospital Care Board Certification equal to or greater than the level applying for.

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**ADDITIONAL FORMS TO BE SUBMITTED FOR AN APPLICATION TO BE COMPLETE:**

**National Practitioner Data Bank (NPDB) self-query.** This form can be obtained by calling the NPDB at 800-767-6732 or visit [www.npdb-hipdb.com](http://www.npdb-hipdb.com) on the Internet. This form must be mailed directly to NPDB at the address indicated in the instructions on their form. The results will come to you; upon receipt please forward them to the Board office (letter unopened).

**APPLICATION PROCEDURES:**

**A verification of licensure or letter of good standing must be sent directly from each state board in which the applicant is currently or has ever been licensed to practice.** Please make copies of the attached verification request form as needed. Some states charge a fee for verification. Contact each board prior to sending the request. *\*NOTE: A verification form from Montana is not necessary; another state's verification form will be accepted.\**

**PROCESSING PROCEDURES:**

An application file must be complete before consideration of licensure.

The applicant will be notified in writing of any items missing from the application file.

An application takes 10 working days to process from the time it is complete.

If the application is considered a non-routine application, there may be a delay in processing of the application.

You may be requested to provide additional information, or make a personal appearance before the Board during a regularly scheduled Board meeting and/or the application may require Board consideration.

A non-routine application may take up to 120 days to process.

**Any application requiring Board review must be complete, with all materials received by the Department, no later than 15 working days in advance of the next scheduled Board meeting. Applications completed after that deadline will not be put on the Board's agenda.**

Any questions with regard to the processing of this application and other concerns please contact the Board of Medical Examiners staff at (406) 444-5711 or e-mail us at [dlibsmed@mt.gov](mailto:dlibsmed@mt.gov)

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EMR

EMT

AEMT

Paramedic

**PLEASE TYPE OR PRINT IN INK.**

(Please allow 10 working days for processing from the date that the Board has a complete routine application)

1. FULL NAME: \_\_\_\_\_

Last

First

Middle

2. OTHER NAME(S) KNOWN BY: \_\_\_\_\_

3. BUSINESS NAME: \_\_\_\_\_

4. BUSINESS ADDRESS: \_\_\_\_\_

Street or PO Box #

City and State

Zip

5. HOME ADDRESS: \_\_\_\_\_

Street or PO Box #

City and State

Zip

PREFERRED MAILING ADDRESS: Business Home

E-MAIL ADDRESS: \_\_\_\_\_

6. TELEPHONE: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Business

Home

Fax

7. SOCIAL SECURITY NUMBER: \_\_\_\_\_

8. DATE OF BIRTH: \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_ FEMALE MALE

City/State

9. LICENSEE NAME: \_\_\_\_\_

(State your name as it should appear on the license if granted.)

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10. Have you ever previously applied for a license to practice in Montana? **Yes No**

If **Yes**, give date and results.

Type of License	Dates	Results of application	Licensure #

11. Have you ever been denied licensure or the opportunity to take a professional licensing examination in any state or country? If yes, attach a detailed explanation.

**Yes No**

12. Have you ever withdrawn an application for an EMT license? If yes, please give the state and reason for withdrawal.

**Yes No**

**Please answer the following questions. If you answer Yes, give specific details (names of organizations, dates, reasons, and outcome) on a Supplement Sheet.**

13. Has a licensing agency ever taken adverse or disciplinary action against your license? If yes, attach agency documents filed in the action including all complaints, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements.

**Yes No**

14. Have you ever voluntarily surrendered, cancelled, forfeited or failed to renew a license as a result of any of the following: having a complaint filed against you; entering into a consent agreement with respect to your license as a result of a complaint; during an investigation or during disciplinary proceedings? If yes, attach a detailed explanation identifying each occasion, the date and the substance of the allegations.

**Yes No**

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15. Is there a pending complaint against you with a professional or occupational licensing agency? If yes, please attach a detailed explanation and provide supporting documentation from the source.

**Yes No**

16. Have you voluntarily or involuntarily surrendered any hospital privileges, health maintenance organization participation, Medicare/Medicaid privileges, or other privileges during a pending investigation, or in anticipation of an investigation, or had such privileges reprimanded, denied, restricted, suspended, placed on probation, revoked or subjected to other sanction or action? If yes, attach a detailed explanation identifying each occasion, the date and the substance of the allegations.

**Yes No**

17. Has any legal or disciplinary action been filed against you, which relates to your propriety of, or your fitness to practice this profession (including malpractice, etc.)? If yes attach a detailed explanation of each instance including the date of the claim, name and address of party complaining, name and address of forum or court where claim was filed, docket or claim number and the substance of the allegations.

**Yes No**

18. Have you ever voluntarily or involuntarily surrendered the privilege to prescribe or dispense any drug, including but not limited to controlled substances, or had such privileges investigated, denied, restricted, suspended, revoked or otherwise modified by any governmental agency, including but not limited to the Drug Enforcement Administration, any state licensing or disciplinary court or other entity?

If yes, attach a detailed explanation.

**Yes No**

19. Have you ever been expelled from or asked to resign from any professional organization or been censured by a professional organization of which you were a member?

If yes, attach a detailed explanation.

**Yes No**

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20. Have you ever been convicted of a misdemeanor or felony crime or do you have a pending criminal charge? "Convicted" for the purposes of this question includes a conviction under appeal, guilty plea, no contest plea, and/or forfeiture of bond. "A pending criminal charge" for the purpose of this question includes a deferred imposition of sentence and/or deferred prosecution. If you answer yes, you must submit a detailed explanation of the events AND the charging documents and final judgments or orders of dismissal. You must report but may omit documentation for: (1) misdemeanor traffic violations older than 10 years and that resulted in fines of less than \$200; and (2) convictions prior to your 18th birthday unless you were tried as an adult.

**Yes No**

21. Have you been diagnosed within the past 5 years with a physical condition or mental health disorder involving potential health risk to the public? If yes please provide a detailed explanation.

**Yes No**

22. Have you used alcohol or any other mood-altering substance in a manner which may have or has adversely affected your ability to practice this profession?  
If yes, attach a detailed explanation.

**Yes No**

23. List all certification/licenses that you hold or ever held, including EMT levels. Verifications for each license must be sent directly to Montana from each state certification/licensing board.

State	License # and Type	Date Issued	Expiration Date	Licensure Method			Requested State verification	
				Exam	Endorse	Other	Yes	No
				Exam	Endorse	Other	Yes	No
				Exam	Endorse	Other	Yes	No
				Exam	Endorse	Other	Yes	No
				Exam	Endorse	Other	Yes	No

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**AFFIDAVIT**

*I authorize the release of information concerning my education, training, record, character, license history and competency to practice by anyone who might possess such information to the Montana Board of Medical Examiners. I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and am familiar with the applicable licensure laws of the State of Montana and instructions to applicants for licensing. I accept the rules and procedures outlined in these documents as the basis for my application.*

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Legal Signature of Applicant

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Dated

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**VERIFICATION OF LICENSURE**

*THIS IS NOT AN ENDORSEMENT CERTIFICATION*

**PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO EACH STATE BOARD IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED TO PRACTICE AS AN EMT, PARAMEDIC OR OTHER EMERGENCY CARE PROVIDER. YOU MAY COPY THIS FORM AS MANY TIMES AS NEEDED. SOME BOARDS REQUIRE A FEE FOR THIS SERVICE.**

**STATE BOARD:** I am applying for a license to practice as an Emergency Care Provider in the State of Montana. The Medical Board requires this form to be completed by each state wherein I hold or ever have held a professional/occupational license. This is your authority to release any information in your files, favorable or otherwise, DIRECTLY to the BOARD OF MEDICAL EXAMINERS, P. O. BOX 200513, 301 SOUTH PARK AVENUE, HELENA, MT 59620-0513. Your early response is appreciated.

Name: \_\_\_\_\_  
(Signature) (Please print)

Address: \_\_\_\_\_

My License Number is: \_\_\_\_\_

**DO NOT DETACH -- THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MONTANA STATE BOARD OF MEDICAL EXAMINERS**

State of \_\_\_\_\_

Full Name of Licensee: \_\_\_\_\_

License Type: EMR EMT AEMT Paramedic Other

License No. \_\_\_\_\_ Issue Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

License is current? Yes No If NO, explain: \_\_\_\_\_

Did licensee take a written practical exam in your state to qualify for licensure? Yes No

Has license been suspended, revoked, placed on probation or otherwise disciplined?  
Yes No If YES, explain and attach documentation

Has licensee ever been requested to appear before your Board? Yes No  
If YES, explain \_\_\_\_\_

Derogatory information, if any: \_\_\_\_\_

Comments, if any: \_\_\_\_\_

Board Seal

Signed: \_\_\_\_\_

Title: \_\_\_\_\_

State Board: \_\_\_\_\_ Date: \_\_\_\_\_