MONTANA BOARD OF MEDICAL EXAMINERS

PO Box 200513
301 South Park Avenue 4th Floor
Helena, Montana 59620-0513
PHONE: 406-841-2300 FAX: 406-841-2305
E-MAIL: dlibsdmed@mt.gov WEBSITE: www.emt.mt.gov

FEES:

$10.00 – Application Fee *(regardless of how many verifications are attached to the application)*

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 Endorsements to be placed on your licensure.

Every endorsement (s) requested require an attached copy of the "Verification of Course Completion Form" for the endorsement(s) applied

APPLICATION PROCEDURES: When the application is complete, it will be processed and considered by Board staff for approval. The applicant may be notified if additional information is required or if required to appear before the Board for an interview.

Keep the Board office informed at all times of any address changes or changes to the originally submitted application. This is essential for timely processing of applications and subsequent licensure.

PROCESSING PROCEDURES:

Once an application is complete, the application takes 10 working days to process from the time it is received in the Board office. The applicant will be notifed in writing of any deficient or missing items from the application submitted.

Any questions with regard to the processing of this application and other concerns please contact the Board of Medical Examiners staff at (406) 841-2300 or e-mail us at dlibsdmed@mt.gov

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Endorsement Application

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. HOME ADDRESS: _____
Street or PO Box # City and State Zip

PREFERRED MAILING ADDRESS: ☐ Business ☐ Home

E-MAIL ADDRESS: _____

3. BUSINESS ADDRESS: _____
Street or PO Box # City and State Zip

4. TELEPHONE: ( ) _____ ( ) _____ ( ) _____
Business Home Fax

5. SOCIAL SECURITY NUMBER: _____

6. LICENSE #:_____ LICENSE TYPE ☐ EMR ☐ EMT ☐ AEMT ☐ Paramedic

I hereby declare under pently of perjury that any information included in this application to be true and complete to the best of my knowledge. I have read and am familiar with the applicable licensure laws of the State of Montana.

_____ _____
Signature of Applicant Date