

MONTANA BOARD OF MEDICAL EXAMINERS
P. O. Box 200513
(301 S PARK, 4TH FLOOR - Delivery)
Helena, Montana 59620-0513
(406)841-2359 FAX (406) 841-2305
E-MAIL: dlibsmed@mt.gov WEBSITE: www.emt.mt.gov

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.

(Please allow 30 days for processing from the date that the Board has a complete routine application)

FEES

\$10.00 Application Fee

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

DOCUMENTS

The following documents must be submitted to the Board office in order to complete your endorsement application. Please make 8 ½" x 11" copies of the following and submit with your application.

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

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 up to 30 days to process from the time it is received in the Board office.

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

For information with regard to the processing of this application or other concerns please contact the Board of Medical Examiners staff at 444-5711 or email us at dlibsmed@mt.gov

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Endorsement Application

PLEASE TYPE OR PRINT IN INK.

1. FULL NAME: _____
Last First Middle

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

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

PREFERRED MAILING ADDRESS: Business Home E-MAIL ADDRESS: _____

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

5. SOCIAL SECURITY NUMBER: _____ FOREIGN ID NUMBER: _____

6. LICENSE #: _____ LICENSE TYPE: First Responder Basic
 Intermediate Paramedic

I hereby declare under penalty 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