Montana Board of Medical Examiners
PO Box 200513
301 S. Park Avenue, 4th Floor
Helena, Montana 59620-0513

Phone: (406) 444-6880 Email: DLIBSDHELP@MT.GOV

COMMUNITY INTEGRATED HEALTH CARE ENDORSEMENT

Community Integrated Health Care is an endorsement which indicates a licensee has attended a board-approved community integrated health care training program that is authorized to offer and conduct ECP courses.

REQUIREMENTS AND APPLICATION CHECKLIST FOR COMMUNITY INTEGRSTED HEALTH CARE ENDORSEMENT

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Phone: 406-444-6880 Email: dlibsdhelp@mt.gov
Website: www.emt.mt.gov

Requirements for Community Integrated Health Care (CIHC) Endorsement

Below are the minimum requirements for endorsement CIHC in Montana.

1. Completion of a board-approved curriculum in Community-Integrated Health Care provided by an accredited institution of higher learning, which must include 48 hours of clinical experience
2. A minimum of 1 year of experience at the applicant's current level of licensure.

Checklist of Required Documents to Submit with Endorsement Application

☐ An official transcript or certificate of completion showing course completion of a board-approved curriculum in CIHC

Application Fee for CIHC Endorsement

The following fee must be submitted with your application. Online applicants can pay using a credit card or e-check. If you submit a paper application you must submit a check. Do not mail cash.

☐ $10

You can apply for a license online at https://ebiz.mt.gov/POL/ or download a paper application from the website. Online application is recommended.

Please include a valid e-mail address with your application. E-mail is the department's primary form of communication.

If you have any questions about the application process or the licensing requirements please contact the Department of Labor and Industry Professional Licensing Bureau using the contact information at the top of this checklist.

Forward:

The Montana Board of Medical Examiners (BOME) developed the ECP endorsement process to provide the local EMS medical director the ability to expand the individual ECP scope of practice. The BOME has defined the "maximum allowable" skills for each endorsement and established statewide protocols. The endorsement process consists of education and verification.

The local EMS medical director is responsible for verifying an ECP's knowledge and skills for a particular endorsement. This can be accomplished via a training program; or the medical director may take into account an ECP's previous education, skill ability or other personal knowledge to determine whether an ECP meets the endorsement knowledge and skill requirements. The local medical director is responsible for the quality of all endorsement training via direct participation and/or oversight.

The medical director cannot exceed the scope of the endorsement.

The endorsement process requires that the medical director complete a standardized "verification form" documenting that an individual ECP has the knowledge and skills identified at the specific endorsement level.

The individual ECP then submits an endorsement application to the Board to establish the endorsement on their license. The medical director then has the option of granting permission to the individual ECP to perform the endorsement to the extent defined by the medical director. All forms and endorsement materials can be obtained from the web site; www.emt.mt.gov. Any questions or concerns can be addressed to dlibsdhelp@mt.gov

MONTANA BOARD OF MEDICAL EXAMINERS
PO Box 200513
(301 South Park Avenue 4th Floor – Delivery Only)
Helena, Montana 59620-0513
Phone (406) 841-2359 FAX (406) 841-2305
E-MAIL: dlibsdmed@mt.gov WEBSITE: www.emt.mt.gov

Community Integrated Health Care 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: ◯ **EMR** ◯ **EMT** ◯ **Advanced EMT** ◯ **Paramedic**

7. NAME OF CIHC COURSE: _____

DATE OF COMPLETION: _____

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.

I attest that I have at least one year of experience at my current level of licensure in accordance with ARM 24. 156.2753.

_____
Signature of Applicant Date

Licensee Name (print): _____
License Number: _____ Date: _____

To be completed by medical director:

I certify that _____ is competent in the above terminal objectives regarding the Community Integrated Health Care Endorsement. Their training and education was conducted according to Board policies and procedures.

_____ _____
Signature of Medical Director Printed Name

Montana License Number_____