



Montana Board of Medical Examiners

PO Box 200513
301 S Park, 4th Floor
Helena, MT 59620-0513
Phone: 406-444-6880

Email: DLIBSDHELP@MT.GOV Website: EMT.MT.GOV

Licensing Requirements and Application Checklist Emergency Care Provider (EMR, EMT, AEMT, Paramedic)

License Requirements for Emergency Care Provider

1. Completion of a course of ECP instruction – [MCA [50-6-203](#), [ARM 24.156.2711](#)]
2. Active or inactive NREMT certification OR current EMR, EMT, AEMT or Paramedic licensure in another state in which applicant originally tested and has a complaint process. [MCA [50-6-203](#), [ARM 24.156.2711](#)]

Checklist of Required Documents to Submit for Application for Emergency Care Provider

The following documents and additional forms are required in addition to the application. State licensure verifications must be sent to the board directly from the source.

- Verification of course completion.
- Proof of active or inactive NREMT certification at or above the level of licensure sought OR a current unrestricted license or certification at or above the level of licensure sought, in another state in which the applicant was originally tested and which has a complaint process.
- If you answered yes to discipline questions, include a detailed explanation on the event(s) and documentation from the source (licensing board, federal agencies/programs, or civil/criminal court proceedings such as initiating/charging documents, sentencing documents, final disposition/judgment documents, etc.).

Application Fee(s) for Emergency Care Providers

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

- \$20 application fee for EMR
- \$35 application fee for EMT
- \$55 application fee for AEMT
- \$75 application fee for Paramedic

License applications are online at EBIZ.MT.GOV/POL. They may also be downloaded from the board's website. Online application is recommended.

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.

MONTANA BOARD OF MEDICAL EXAMINERS

PO Box 200513

301 South Park Avenue 4th Floor

Helena, Montana 59620-0513

PHONE: 406-444-6880

FAX: 406-841-2305

E-MAIL: DLIBSDHELP@MT.GOV

WEBSITE: EMT.MT.GOV

EMR

EMT

AEMT

Paramedic

PLEASE TYPE OR PRINT IN INK.

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

7. SOCIAL SECURITY NUMBER: _____

8. DATE OF BIRTH: _____

Have you completed a course for the license level or above the level for which you are applying?

Yes

No

9. Have you ever previously applied for or held a Montana license?
If **Yes**, give date and results.

Yes **No**

Type of License	Dates	Results of application	License Number

10. NREMT Certification Number: _____

NREMT Status:

Active Inactive Lapsed

PERSONAL HISTORY QUESTIONS

- Read the following questions carefully. Giving an incomplete or false answer is unprofessional conduct and may result in denial of your application or revocation of your license. See, 37-1-105, MCA.
- You have a continuing duty to update the information you provide in your application and supplemental responses, including while your application is pending and after you are issued a license.
- Upon submittal of your application form, for every "yes" answer provided, you will receive a request for specific information or documents associated with the question. Your application is not complete until staff receive all information requested.

11. Have you ever had any license, certificate, registration, or other privilege to serve as a volunteer or practice a profession denied, revoked, suspended, or restricted by a public or private local, state, federal, tribal, religious, or foreign authority?

Yes **No**

12. Have you ever surrendered a credential like those listed in question 11, in connection with or to avoid action by a public or private local, state, federal, tribal, religious, or foreign authority?

Yes **No**

13. Have you ever resigned to avoid discipline, been suspended, or been terminated from a volunteer or employment position?

Yes **No**

14. Have you ever been required to participate in a behavioral modification or assistance program in lieu of suspension or termination from a volunteer or employment position?

15. Have you ever withdrawn an application for any professional license? Yes No
16. As of the date of this application, are you aware of any pending complaint, investigation, or disciplinary action related to any professional license you hold? Yes No
17. Are you under a current order that remains unsatisfied (e.g., fines unpaid, probation not concluded, conditions unmet?) Yes No

Note on Questions 18 and 19:

Applicants who disclose medical, physiological, mental, or psychological conditions or chemical substance use in Question 18 or 19 may qualify for participation in the Montana Recovery Program. Please visit the board website for more information about this program. "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

18. Do you have any medical, physiological, mental, or psychological condition which in any way currently (within the last 6 months) impairs or limits your ability to practice your profession or occupation with reasonable skill and safety? Yes No
19. Do you currently (within the last 6 months) use one or more chemical substances in any way which impairs or limits your ability to practice your profession or occupation with reasonable skill and safety? Yes No

Note on Question 20:

A criminal conviction may not automatically bar you from receiving a license. For more information about how a criminal conviction may impact your application, consult the board or program website.

20. Have you ever been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or sentence deferred or suspended as an adult or "juvenile convicted as an adult" in any state, federal, tribal, or foreign jurisdiction? Yes No
21. Are you now subject to criminal prosecution or pending criminal charges? Yes No
22. Have you ever been disciplined, censured, expelled, denied membership or asked to resign from a professional society or organization? Yes N

23. Have you ever had a civil judgment entered against you in a lawsuit for incompetence, negligence, or malpractice in practicing any profession? Yes No

24. Have you ever been disqualified from working with children, elderly persons, mentally ill persons, or other vulnerable persons? Yes No

25. Have you ever been placed on probation, restricted, reprimanded, suspended, revoked, resigned in lieu of action against you, or had other action taken against you by any hospital, clinic, health care facility, group medical practice, health maintenance organization, or third-party insurance provider, including Medicare and Medicaid? Yes No

26. Are you currently on an exclusion list by the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services prohibiting you from working in a facility receiving federal funding? Yes No

List licenses you hold or have held in other jurisdictions. Then send the "Request for Verification" page to all of those licensing offices.

State	License Number	License Type	Date Issued	Expiration Date	Licensure Method	Requested State verification
					<input type="radio"/> Exam <input type="radio"/> Endorse	<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Exam <input type="radio"/> Endorse	<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Exam <input type="radio"/> Endorse	<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Exam <input type="radio"/> Endorse	<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Exam <input type="radio"/> Endorse	<input type="radio"/> Yes <input type="radio"/> 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 understand my recurring duty to comply with continued competency requirements as part of license renewal and my responsibility to maintain documentation of my continued competency and my medical director's authorization/ attestation of continued competence (including endorsement skills) on which shall be made available to the board upon request. I accept the rules and procedures outlined in these documents as the basis for my application.

Legal Signature of Applicant

Dated

REQUEST FOR VERIFICATION OF LICENSURE/CERTIFICATION AND EXAMINATION AS EMERGENCY CARE PROVIDER



Date _____

TO: _____

From: Montana Board of Medical Examiners
Box 200513, Helena, MT 59620-0513
email: dlibsmed@mt.gov

Regarding Name: _____
SS#: _____
DOB: _____

The above-named person currently is certified or licensed as:

	Certificate/License No.	Date Issued	Valid Until
<input type="checkbox"/> EMR (or EMT-F or EMT-FR)	_____	_____	_____
<input type="checkbox"/> EMT (or EMT Basic)	_____	_____	_____
<input type="checkbox"/> Advanced EMT (or EMT-I)	_____	_____	_____
<input type="checkbox"/> Paramedic (or EMT-P)	_____	_____	_____
<input type="checkbox"/> Other	_____	_____	_____

This is: A license to practice issued by a licensing board or other licensing authority
 Registration with a state agency or a certificate issued by a state agency

Basis of Licensure/Certification:

- NATIONAL REGISTRY CERTIFICATION (Current NREMT card in place at time of licensure)
- AMERICAN BOARD OF PRE-HOSPITAL CARE (Current certification at time of licensure)
- STATE-SPECIFIC WRITTEN & PRACTICAL EXAMINATION (Pre-licensure exam specifically for EMS practice in this state)
- RECIPROCITY WITH ANOTHER STATE (No NREMT or ABPC certification and no examination in this state)

Questions:

1. Does your state have a compliance/disciplinary process for Emergency Care Providers?
 YES NO
2. Has any disciplinary action ever been taken against the applicant? YES NO
3. If so, has this disciplinary case been satisfied to the board's requirements? YES NO

If not, give details _____

BY: _____ TITLE: _____ DATE: _____