



## EMT-PARAMEDIC INITIAL / RE-ACCREDITATION / TRANSFER APPLICATION FORM

**INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED**  
**PLEASE ATTACH COPIES BEFORE SUBMITTING YOUR APPLICATION - APPLICATION PROCESSING**  
**TIME IS 15 BUSINESS DAYS FROM RECEIPT OF ALL REQUIRED DOCUMENTATION**

### Initial Applicants:

- ☐ Completed, original EMT-P application, which includes verification of employment by an approved San Francisco (SF) ALS provider and completion of orientation to EMS system and field evaluation (see page 3)
- ☐ Copy of current State of California Paramedic License
- ☐ Copy of current ACLS card
- ☐ Copy of current PALS or PEPP card
- ☐ Copy of current BTLS, PHTLS, or ITLS card
- ☐ Copy of current California Driver's License
- ☐ Copy of current Healthcare Provider CPR card
- ☐ Check/money order for \$31.00 payable to the "City and County of San Francisco"

### Re-Accreditation Applicants:

- ☐ Completed, original application which includes verification of employment by an SF ALS Provider (see page 3)
- ☐ Copy of current San Francisco EMT-P Accreditation card
- ☐ Copy of new State of California Paramedic License
- ☐ Copy of current California Driver's License
- ☐ Copy of current ACLS card
- ☐ Copy of current PALS or PEPP card
- ☐ Copy of current Healthcare Provider CPR card
- ☐ Check/money order for \$31.00 payable to "City & County of San Francisco" **IF ACCREDITATION HAS LAPSED**

### Notice of Transfer of Accreditation to Another ALS Employer:

- ☐ Complete and submit information on page 3 application form.

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**CHECK ONE:**    ☐ INITIAL        ☐ RE-ACCREDITATION        ☐ TRANSFER (Only complete page 3)

Current San Francisco EMT-P Accreditation # \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Cell Telephone # (    ) \_\_\_\_\_ - \_\_\_\_\_ Home Telephone # (    ) \_\_\_\_\_ - \_\_\_\_\_

Drivers License # \_\_\_\_\_ E-mail Address Optional) \_\_\_\_\_

California State EMT-P License # \_\_\_\_\_

New EMT-P License Issue Date \_\_\_\_/\_\_\_\_/\_\_\_\_ New EMT-P License Expiration Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Current Employer \_\_\_\_\_

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**ANSWER EACH OF THE FOLLOWING QUESTIONS BEFORE SIGNING THE APPLICATION:**

☐ **yes** ☐ **no** Have you ever had a certification, accreditation, or professional license denied, suspended, revoked, placed on probation, or are you under investigation at this time?

*If yes, attach a written explanation.*

☐ **yes** ☐ **no** Have you ever been convicted of any felony or misdemeanor offense in California or in any other state or place, including entering a plea of nolo contendere or no contest, and including any conviction which has been expunged (set aside) under Penal Code Section 1203.4?

*If yes, attach a written explanation.*

I hereby certify under penalty of perjury that all information on this application is true and correct to the best of my knowledge and belief. I understand any falsification or omission of material facts may cause forfeiture on my part of all rights to EMT-P Accreditation/Re-Accreditation in the State of California.

I understand all information on this application form is subject to verification, and I hereby give my express permission for the San Francisco EMS Agency to contact my employer, previous employer(s), prospective employer and certifying/accrediting agency(ies) for information related to my position and/or accreditation.

Local accreditation is valid for a 2 year period, or until such time as your EMT-Paramedic license is renewed or expired, and is contingent upon maintaining employment as an EMT-Paramedic with a permitted San Francisco ALS Provider.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Attach all required documents to the application and mail or drop off to:

SF EMS Agency  
Attn: Accreditation  
30 Van Ness Avenue, Suite 3300  
San Francisco, CA 94102-6027

**FOR EMSA USE ONLY:**

Application Received in Person on \_\_\_\_\_ by \_\_\_\_\_ Application Received by Mail on \_\_\_\_\_  
For Initial/Lapsed Accreditation: Check/MO # \_\_\_\_\_ in the Amount of \$ \_\_\_\_\_  
ACLS Expiration Date \_\_\_\_\_ PALS/PEPP Expiration Date \_\_\_\_\_  
BTLS/PHTLS/ITLS Expiration Date \_\_\_\_\_ CPR Expiration Date \_\_\_\_\_  
SF EMT-P Accreditation # \_\_\_\_\_ Issue Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

**THIS FORM TO BE COMPLETED BY THE ALS PROVIDER  
FOR INITIAL EMT-P ACCREDITATION CANDIDATES ONLY**

1. Enter initials for the authorized provider below to verify that candidate has successfully completed:
- \_\_\_\_\_ Provider based orientation to the SF EMS system
  - \_\_\_\_\_ 24 hours of Field Orientation and Operations training with competency evaluation
  - \_\_\_\_\_ ICS 100 and 200; IS 700a and Hazmat 1<sup>st</sup> Responder Awareness Training
  - \_\_\_\_\_ Training and testing in SF Optional Scope of Practice
2. If candidate is employed by an ALS Provider with less than 1 year of service in SF, attach verification from previous employers that candidate has 2 years of ALS emergency response experience in the last 3 years.  
☐ Documentation attached    or    ☐ Not applicable
3. This is to verify that the candidate meets all requirements and to recommend accreditation:  
Name of Provider Organization \_\_\_\_\_
- Provider Authorization \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_  
Signature (Original required)
- Provider Authorization \_\_\_\_\_  
Print Name \_\_\_\_\_
- Upon return receipt from the EMS Agency, this form with any/all attachments will be kept on file with the above named ALS Provider Agency through the duration of the applicant's employment.  
Accreditation must be renewed concurrent with the State of California Paramedic License.

**FOR EMT-P RENEWAL ACCREDITATION APPLICANTS ONLY**

- ALS Provider has the following on file for the applicant:
- ☐ Current State of California Paramedic License
  - ☐ Current ACLS Provider or Instructor Certificate
  - ☐ Current PEPP or PALS Provider or Instructor Certificate
  - ☐ Proof of completion of training on the annual and off-cycle policy and protocol revisions that have been issued in the previous 12 months and are currently in effect
  - ☐ Verification, when applicable, of completion of any training as required by the San Francisco EMS Agency Medical Director as part of individual or system-wide quality improvement.
- ☐ **Check box if not applicable.**

Name of Provider Organization: \_\_\_\_\_

Provider Authorization Name \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_  
Signature (Original required)

Provider Authorization: \_\_\_\_\_  
Print Name \_\_\_\_\_

**NOTICE OF TRANSFER OF ACCREDITATION TO ANOTHER ALS EMPLOYER**

1. Submit this form to the SF EMSA at least 2 business days in advance of assignment to the field.
- Name of EMT-P \_\_\_\_\_ \*Current SF EMT-P Accreditation \_\_\_\_\_  
Previous Employer \_\_\_\_\_ Date EMT-P left previous employer \_\_\_\_\_  
New Employer \_\_\_\_\_ Date of Hire \_\_\_\_\_
- \*If lapsed, EMT-P must complete the renewal application form per SF EMSA Policy requirements.
2. ☐ This individual has on file with new employer, proof of training on annual and off-cycle policy and protocol revisions that have been issued in the previous 12 months and are currently in effect.
- Provider Authorization \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_  
Signature (Original required)
- Provider Authorization: \_\_\_\_\_  
Print Name \_\_\_\_\_