STATE USE ONLY
P.M.:_____Rec.:_____By:___
1st $ _____Type _____ R#_____
2nd $_____Type _____ R#_____
☐ Scanned ☐ QC

STATE OF CALIFORNIA
REINSTATEMENT PARAMEDIC LICENSE APPLICATION
Lapsed Less Than 1 Year

Please type or print clearly. The **non-refundable** fee of **$300** may be paid by credit card (complete credit card authorization form), check, or money order made payable to **EMS PERSONNEL FUND.**

PARAMEDIC LICENSE NUMBER

PARAMEDIC LICENSE NUMBER:	LICENSE EFFECTIVE DATE:	LICENSE EXPIRATION DATE:

PERSONAL INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:

RESIDENTIAL ADDRESS:	CITY:	STATE:	ZIP CODE:

DATE OF BIRTH (MM/DD/YYYY):	LAST FOUR (4) DIGITS OF SSN or TIN #:	Required, per Health & Safety Code 1797.172(c)

HOME PHONE NUMBER:	CELL PHONE NUMBER:	EMAIL ADDRESS: ☐ Do not send EMSA correspondence via email.

MAILING ADDRESS *(EMSA will send official correspondence to this address)*

☐ Same as residential. If not, complete the below:

MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:

EMPLOYER INFORMATION, IF KNOWN

EMPLOYER NAME:	EMPLOYER PHONE NUMBER:

EMPLOYER ADDRESS:

QUESTIONNAIRE *(Answers are required or your application will be returned.)*

1. Have you 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) or records sealed under Penal Code Section 1203.4 that you have not previously disclosed?	YES ◯ NO ◯
2. Are there any criminal charges currently pending against you that have not been previously disclosed?	YES ◯ NO ◯
3. Is your healthcare certification, accreditation, or license currently under investigation or have they been denied, suspended, revoked, fined, or placed on probation that you have not previously disclosed?	YES ◯ NO ◯

Important Notice

If you marked YES to any of these questions and have not previously disclosed the details, **attach a detailed statement** describing the accusation, charge(s)/conviction(s), case #, date, location, court, sentence served, parole or probation status **or** an applicable EMSA case number. Refer to instructions for more information.

SIGNATURE

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, and I understand that any falsification or omission of material facts may cause forfeiture on my part of all rights to paramedic licensure in the State of California. I understand all information on this application is subject to verification, and I hereby give my express permission for the EMS Authority to contact any person or agency for information related to my role and function as a paramedic in California.

SIGNATURE OF APPLICANT:_____ **DATE** _____

CONTINUE NEXT PAGE (INSTRUCTIONS)

Clear Form Print

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STATEMENT OF CONTINUING EDUCATION (CE)

Acceptable CE courses must have been issued within the last two (2) years from the date the application is received by the EMS Authority.

LAPSED 0-6 MONTHS → MINIMUM OF 48 HOURS REQUIRED

LAPSED 6 MONTHS-UNDER 1 YEAR → MINIMUM OF 60 HOURS REQUIRED

(50% of total hours submitted must be instructor based CE's)

INSTRUCTOR BASED CE'S

Courses that provide an available instructor to respond to student questions.
Courses 20 hours or more must include the beginning and ending dates.

Date(s) of Course *(mm/dd/yy)*	Course Title	Approved Pre-hospital CE Provider Name	Approved Pre-hospital CE Provider Number	Total CE Hrs.
			Total Instructor Based Hours=	

OTHER APPROVED CE'S

Courses that include instructor/teacher, preceptor, and non-instructor based CE hours.

Date(s) of Course	Course Title	Approved Pre-hospital CE Provider Name	Approved Pre-hospital CE Provider Number	Total CE Hrs.
			Total Other Approved CE Hours=	

REINSTATEMENT PARAMEDIC LICENSE APPLICATION
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✓	INSTRUCTIONS
	Complete the Reinstatement Paramedic License application; including the Statement of Continuing Education. Please ensure the CE's listed are from approved providers. Lists of approved providers can be found on EMSA's website at www.emsa.ca.gov and at www.capce.org. Incomplete applications will be returned.
	Sign and date the application. Only original signatures are accepted.
	Attach copies of your CE Certificates for all CE's listed on the application: ➢ Reinstatements for those lapsed 0-6 months, submit a minimum of 48 CE hours. ➢ Reinstatements for those lapsed 6 months – under 1 year, submit a minimum of 60 CE hours. For the complete regulations related to CE requirements, please refer to the California Code of Regulations. The regulations can be found at http://www.emsa.ca.gov/legislation regulations.
	If you answered YES to any questions in the Questionnaire section, attach a detailed statement describing the charge(s)/conviction(s), case number, date, location, court, sentence served, parole or probation status or an applicable EMSA case number. You may attach applicable certified court documents and police reports to help expedite the review of your application.
	Include payment in the amount of $300.00 with your application. This **non-refundable** fee may be paid by credit card (include a completed credit card authorization form), check, or money order made payable to **EMS PERSONNEL FUND.**
	Mail the application, payment, and required documents to the following address: California Emergency Medical Services Authority Paramedic Licensure Unit 10901 Gold Center Drive, Suite 400 Rancho Cordova, CA 95670

For additional information:

- See our Frequently Asked Questions (FAQ's) and/or the Informational Videos at http://www.emsa.ca.gov/Paramedic *or*
- Send your inquiries to the Emergency Medical Services Authority at paramedic@emsa.ca.gov *or*
- Contact us by phone at (916) 323-9875

CALIFORNIA EMERGENCY MEDICAL SERVICES AUTHORITY
PARAMEDIC LICENSURE PROGRAM
10901 Gold Center Drive, Ste. 400, Rancho Cordova, CA 95670-6073
TELEPHONE (916) 323-9875 / FAX (916) 324-2875
paramedic@emsa.ca.gov

STATE USE ONLY

Receipt Number: _____

CREDIT CARD AUTHORIZATION FORM

Card Type:

Visa ☐

Mastercard ☐

Debit ☐

Applicant Name: _____ **P-Number** _____
(If applicable)

Name: _____
(As name appears on card)

Credit Card Number: _____
*Only Visa and Mastercard credit cards are accepted

Expiration Date (MM/YY): _____

CVC2 Code (Security Code): _____ Billing Zip Code: _____

Payment Amount: _____

Signature of Cardholder: _____

To receive a receipt of payment, please provide your email address:

_____

Do not add application information to this form. It will be shredded.

Clear Form Print

Revised: 10/30/18
Created: 04/14/16