



APPLICATION FOR CERTIFICATION AS A FIRST RESPONDER

IMPORTANT: This completed application must be kept by the teaching institution for a minimum of four years from the course ending date. Please type or print legibly in black or dark blue ink only.

Have you ever applied for First Responder certification in Oregon? [] yes [] no

If yes, when? ___/___/___

[] Initial Application [] Recertification Application

NAME: _____ (Last) (First) (M.I.) (Date of Birth)

Social Security # _____ - _____ - _____

ALSO KNOWN AS: _____ (Last) (First) (M.I.)

MAILING ADDRESS: _____ (Street or P.O. Box) (City) (County) (State) (Zip)

TELEPHONE: (____) _____ (____) _____ (Home Number) (Work or Message Number)

Emergency Medical Service Agency Affiliation (if any): _____

ADDRESS: _____ (Street or P.O. Box) (City) (County) (State) (Zip)

FIRST RESPONDER COURSE INFORMATION

IMPORTANT: This section must be completed and signed by the course director.

Type of Course: [] Initial Course [] Initial Course with Automatic/Semi-automatic Defibrillation [] Refresher Course [] Recertification using Written and Practical Examination Only

Course Affiliation: _____ (Community College or Public or Private Safety Agency) (City)

Dates of Course: Beginning ___/___/___ Completion ___/___/___

Written Examination - Attempts: 1st: ___% 2nd: ___% 3rd: ___% Minimum passing score is 75%.

Practical Examination -Attempts: 1st: ___P ___F 2nd: ___P ___F 3rd: ___P ___F Must pass all skill stations.

Course Director: _____ (Last) (First) (M.I.)

I certify that the above-named applicant has successfully completed a Health Division-approved First Responder course as indicated above and is eligible to receive a First Responder Certificate of Course Completion.

_____/_____/_____ (Signature of Course Director) Date

Last Name First M.I.

PERSONAL HISTORY

This information is used to determine eligibility for certification as a First Responder. If you are applying for recertification, questions 2, 3, 4 and 5 pertain to the previous certification period only. If answering yes to any of the following, enclose a detailed explanation including date (s) and location in a separate envelope marked "confidential".

1. Have you been diagnosed with any mental or physical impairment (s) that may affect your ability to perform all the essential duties and functions of the certification level for which you are requesting, as defined in ORS Chapter 682, the Oregon Health Division's "Job Description for EMT", and the "Functional Job Analysis" in the most recent DOT EMT curriculum for that level of certification? Yes No
2. Have you engaged in the use of any chemical substance for other than legitimate medical purposes or been treated for addiction or dependency? Yes No
3. Have you engaged in the habitual use of alcohol or received treatment for alcoholism? Yes No
4. Have you been convicted of any misdemeanor, felony or other crime? Felony or misdemeanor traffic crimes and any involving driving while impaired, intoxicated, or under the influence of any drug or alcohol (DUI, DUUI, etc.) MUST be reported. (Minor traffic violations need not be reported) Yes No
5. Have you been disciplined by your employer or supervising physician? (Discipline would include any of the following: limitation or restriction of scope of practice; suspension, letter of reprimand, or dismissal for cause.) Yes No
6. Have you been named in a lawsuit alleging medical malpractice or misconduct? Yes No
7. Have you been disciplined, denied or revoked by the National Registry of EMT's or any certifying agency? Yes No

I certify that to the best of my knowledge, I am physically and mentally qualified to act as a First Responder, that I am free from addiction to controlled substances or alcoholic beverages, or if not so free, that I am currently rehabilitated, that I am free from epilepsy or diabetes, or if not so free, that I have been free from any lapses of consciousness or control occasioned thereby for a period of at least one hundred eighty (180) days.

I have carefully read the questions in the forgoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of my First Responder certificate by the State of Oregon.

(Signature of Applicant) (Date)

(OREGON HEALTH DIVISION USE ONLY)

As an authorized representative of the Oregon Health Division, Emergency Medical Services and Systems Section, I have reviewed the personal history answers of the above named applicant. Based on the review which may have included an informal interview, written responses to any of the four questions listed above or other written documentation received, the First Responder applicant's physical or mental condition at this specific time is such that a First Responder certificate

- may be issued to the applicant, if the applicant has met all other course requirements.
- is denied. The reason(s) for the denial will be provided directly to the applicant.

Dated this ____ day of _____, _____

(Signature of Health Division Representative)