

Emergency Medical Response Team Healthcare Provider Application

Please check which team you are applying for:

- Maine - New Hampshire

(Applicants will be limited to one team and must hold a license to practice in the state of the team they wish to join)

<i>Personal Information:</i>	
Title: _____	First Name: _____ Middle Name: _____
Last Name: _____	Suffix: _____
Preferred Name: _____	
Home Mailing Address: _____	
City: _____	State: _____ Zip + 4: _____ - _____
Home Telephone: () _____ - _____	
Mobile Telephone: () _____ - _____	
Pager: () _____	ID # _____
Date of Birth: ____ / ____ / ____ Social Security Number: ____ - ____ - ____	
Drivers License State: ____ Number: _____	

<i>Professional Information:</i>					
Please check and complete all that apply. Enclose legible photocopies of all medical certifications and or licenses, one per page please. Please also include a copy of your driver's license, passport if you have one, and DEA license if applicable.					
<input type="checkbox"/>	APRN	Specialty:		State/s of licensure:	<input type="checkbox"/> - Maine <input type="checkbox"/> - New Hampshire <input type="checkbox"/> - Vermont
<input type="checkbox"/>	DO	Specialty:		State/s of licensure:	<input type="checkbox"/> - Maine <input type="checkbox"/> - New Hampshire <input type="checkbox"/> - Vermont
<input type="checkbox"/>	EMT	Level:	<input type="checkbox"/> - FR / ECA <input type="checkbox"/> - Basic <input type="checkbox"/> - Intermediate <input type="checkbox"/> - Paramedic	State/s of certification / licensure:	<input type="checkbox"/> - Maine <input type="checkbox"/> - New Hampshire <input type="checkbox"/> - Vermont
<input type="checkbox"/>	LPN	State/s of licensure:		<input type="checkbox"/> - Maine <input type="checkbox"/> - New Hampshire <input type="checkbox"/> - Vermont	
<input type="checkbox"/>	MD	Specialty:		State/s of licensure:	<input type="checkbox"/> - Maine <input type="checkbox"/> - New Hampshire <input type="checkbox"/> - Vermont
<input type="checkbox"/>	MSW	State/s of licensure:		<input type="checkbox"/> - Maine <input type="checkbox"/> - New Hampshire <input type="checkbox"/> - Vermont	
<input type="checkbox"/>	PA	Specialty:		State/s of certification / licensure:	<input type="checkbox"/> - Maine <input type="checkbox"/> - New Hampshire <input type="checkbox"/> - Vermont
<input type="checkbox"/>	PharmD	State/s of licensure:		<input type="checkbox"/> - Maine <input type="checkbox"/> - New Hampshire <input type="checkbox"/> - Vermont	
<input type="checkbox"/>	Psychologist	State/s of licensure:		<input type="checkbox"/> - Maine <input type="checkbox"/> - New Hampshire <input type="checkbox"/> - Vermont	
<input type="checkbox"/>	RT	State/s of licensure:		<input type="checkbox"/> - Maine <input type="checkbox"/> - New Hampshire <input type="checkbox"/> - Vermont	
<input type="checkbox"/>	RN	State/s of licensure:		<input type="checkbox"/> - Maine <input type="checkbox"/> - New Hampshire <input type="checkbox"/> - Vermont	
<input type="checkbox"/>	Other	Type:		State/s of certification / licensure:	<input type="checkbox"/> - Maine <input type="checkbox"/> - New Hampshire <input type="checkbox"/> - Vermont

<i>Relevant Certifications and Training:</i>					
Please check off all current certifications or training. Enclose legible photocopies, one certification or proof of training per page please.					
<input type="checkbox"/>	ACLS	<input type="checkbox"/>	ADLS	<input type="checkbox"/>	APLS
<input type="checkbox"/>	ATLS	<input type="checkbox"/>	BDLS	<input type="checkbox"/>	BTLS
<input type="checkbox"/>	CPR - Adult	<input type="checkbox"/>	CPR - BLS Healthcare Provider	<input type="checkbox"/>	CPR - Infant and Children
<input type="checkbox"/>	CPR - Professional Rescuer	<input type="checkbox"/>	First Aid	<input type="checkbox"/>	HEICS
<input type="checkbox"/>	ICS-100	<input type="checkbox"/>	ICS-200	<input type="checkbox"/>	ICS-300
<input type="checkbox"/>	ICS-400	<input type="checkbox"/>	NALS	<input type="checkbox"/>	NIMS
<input type="checkbox"/>	PALS	<input type="checkbox"/>	PHTLS	<input type="checkbox"/>	REACTS
<input type="checkbox"/>	Other (Please Describe):				

<i>Understanding of Team Membership Responsibilities:</i>	
Please read and initial after each statement signifying that if accepted to the Emergency Medical Strike Team you will commit to these minimum responsibilities. Failure to comply with these responsibilities will put your membership with the team in jeopardy.	
I understand:	Initials:
I will attend 6 team meetings per year, which will be combined with training sessions	
I will respond promptly to all tests for deployment availability either actual or a test	
I will respond promptly to all notifications for team activation 90 minutes for an actual deployment 24 hours for a delayed or scheduled deployment	
I will attend be available for all mandatory team trainings, meetings, and deployments	
I will respond promptly to all administrative requests for information and advise regional and state commanders of any contact information changes.	
I will keep team command staff updated on any medical conditions or other circumstances that could interfere with my ability to deploy.	
I will maintain my medical certifications and or licensure current.	
I will be considered "on-call" for deployment if not committed to my employer or another significant obligation.	
While unpredictable, it is reasonable to expect that a deployment will last between 48 and 72 hours.	
I may be required to practice medicine in an austere environment.	
Prior to deployment I must have clearance from my employer.	
Membership in this team is completely voluntary.	

<i>Affirmation of Compliance:</i>				
All applicants will be subject to a criminal background check. NNE MMRS will verify all credentials supplied by the applicant through the respective licensing or certification board.				
Have you ever been convicted of a felony or misdemeanor crime? If yes, please explain on a separate sheet of paper.	No:	<input type="checkbox"/>	Yes:	<input type="checkbox"/>
Has your certification or licensure to practice medicine in any state ever been suspended,	No:	<input type="checkbox"/>	Yes:	<input type="checkbox"/>

restricted, or in some other fashion encumbered? If yes, please explain on a separate sheet of paper.					
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Prior to signing the statement below, please ensure that your application is complete:	
<input type="checkbox"/>	Photocopy of driver's license.
<input type="checkbox"/>	Photocopy of passport, if you have one.
<input type="checkbox"/>	Photocopies of all current medical certifications, licenses, or evidence of completion of specialized training.
<input type="checkbox"/>	Photocopy of your DEA license, if you have one.
<input type="checkbox"/>	A brief statement, no more than one page, indicating why you would like to join the team as well as any special contributions or skills that the application might otherwise not address.
<input type="checkbox"/>	A current curriculum vitae.
<input type="checkbox"/>	At least two reference forms distributed for completion.
<p><i>I understand that this application does not obligate the Northern New England Emergency Medical Response Team to accept me as a Team member. I understand that Team membership is at the discretion of the Team Command and the Northern New England MMRS. If my application is approved, I agree to inform Team Command of any lapsed or revoked licenses or credentials and of any conditions that could affect my ability to meet member commitments or to deploy. I understand that the Team Command has the authority to restrict deployment based on any physical or other condition that concerns them. I hereby certify that all information contained in this application is true and correct. I understand that misrepresentation or the provision of false information on this application may subject me to disciplinary action which may include removal from the team.</i></p>	
Signature of applicant: _____ Date: ____ / ____ / ____	