Yale New Haven Center for EMS
Medical Authorization Application

Yale NewHaven Health
Yale New Haven Hospital

Date _____

DEMOGRAPHICS – ***Please print clearly.***

Name_____
(Last) (First) (Middle Initial) (Maiden Name)

Date of Birth _____

Home Address _____

_____
(City) (State) (Zip Code)

Mailing Address _____

(if different) _____
(City) (State) (Zip Code)

Home Phone #_____ Work Phone #_____

Cell Phone # _____

Personal Email Address_____

Work Email Address_____

(Optional) What best describes your current gender identity?
☐ Man
☐ Woman
☐ Non-binary
☐ Transgender
☐ An identify not listed, please specify:

Yale New Haven Center for EMS
77 Willow Street
New Haven, CT 06511
Phone: 203-562-3320
Fax: 203-562-9070

ynhh.org/cems

YaleNewHavenHealth

LAST NAME:_____**Date:**_____

(Optional) With which race/ethnicity do you identify? (Select all that apply)
☐ African American or Black
☐ American Indian or Alaska Native
☐ Asian American or Asian
☐ Hispanic or Latino/x
☐ White or Caucasian
☐ An identify not listed, please specify:

(Optional) Do you identify as someone who has a disability or impairment?
☐ Yes
☐ No

EDUCATION – ***Please print clearly.***

1. _____
School Name Location Degree Concentration

_____
Start Year End Year Year of Graduation

2. _____
School Name Location Degree Concentration

_____
Start Year End Year Year of Graduation

3. _____
School Name Location Degree Concentration

_____
Start Year End Year Year of Graduation

4. _____
School Name Location Degree Concentration

_____
Start Year End Year Year of Graduation

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LAST NAME:_____**Date:**_____

EMPLOYMENT –***Refers to current employment.***

Primary EMS Employer_____

Start Date_____Approximate hours/week_____

Other EMS Employers

1. _____
   Start Date_____Approximate hours/week_____
2. _____
   Start Date_____Approximate hours/week_____
3. _____
   Start Date_____Approximate hours/week_____

Primary Non-EMS Employer

1. _____
   Start Date_____Approximate hours/week_____

Other Non-EMS Employers

1. _____
   Start Date_____Approximate hours/week_____
2. _____
   Start Date_____Approximate hours/week_____

MILITARY EXPERIENCE

Branch of Service _____Service Number_____

Military Occupational Status_____

Years of Service _____

Overseas Duty Station_____

Reserve Status _____

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LAST NAME:_____**Date:**_____

CERTIFICATION/CREDENTIALS
Please complete for ***all*** levels achieved.
All dates should be listed as ***month*** and ***year***.

EMR

CT EMR Number _____

Location of EMR Course_____

Course Completion Date_____

Initial Certification Date_____

Expiration Date_____

EMT

CT EMT Number _____

Location of EMT Course_____

Course Completion Date_____

Initial Certification Date_____

Expiration Date_____

AEMT

CT AEMT Number _____

Location of AEMT Course_____

Course Completion Date_____

Initial Certification Date_____

Expiration Date_____

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LAST NAME:_____**Date:**_____

Paramedic

CT Paramedic Number _____

NREMT-P Number_____

Location of Paramedic Course_____

Course Completion Date_____

Initial Certification Date_____

Expiration Date_____

EMS Instructor (EMS-I)

CT EMS-I Number _____

Location of EMT-I Course_____

Course Completion Date_____

Initial Certification Date_____

Expiration Date_____

OTHER – Please list all other EMS related certifications such as: BLS, ACLS, PHTLS, PALS, PEPP, BTLS, BDLS, ADLS, etc.

Type	Location of Course	Completion Date	Expiration Date

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LAST NAME:_____Date:_____

Have you ever been convicted of or pled "no contest to" a law violation other than a minor traffic offense? ***(For purposed of this application, reckless driving, evading responsibility, engaging in pursuit, driving while impaired and driving while intoxicated are NOT considered minor traffic offenses.)***

☐ Yes ☐ No

If yes, please explain:

_____

_____

Have you ever been fired or asked to resign from a job? ☐ Yes ☐ No

If yes, please explain:

_____

_____

Are you a United States citizen or are you authorized to work in the United States? ☐ Yes ☐ No

I certify that there are no misrepresentations, omissions or falsifications in the foregoing statements and answers. I further certify that the responses given are true, complete and accurate to the best of my knowledge and are med in good faith. I understand that any misrepresentation, omission or falsification may be grounds for rejection of my application, or immediate revocation of medical control.

Signature:_____

Date:_____

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LAST NAME:_____**Date:**_____

LEVEL OF MEDICAL AUTHORIZATION REQUESTED – Please write your initials next to each level of medical authorization you are applying for.

Medical Authorization Level

EMT_____

Paramedic_____

EMS Instructor_____

COMMENTS – Please include any other pertinent information you think we should know about you!

_____

_____

_____

_____

_____

Applicant's Printed Name: _____

Signature:_____

Date:_____