# MESA COUNTY EMS SYSTEM CREDENTIALS APPLICATION

**I. Identifying Information** *Please provide your full legal name.*

A. Last Name: ______________________ First: ________________ Middle: ___________________

B. Other name Used? ☐ Yes ☐ No

If yes, Name(s) used:_____________________________________________

C. Home Address: ______________________________________________

City: _____________________ State: ___________________ Zip: ________

D. Contact Information
Phone: ___________________ Phone: _____________________
Email:____________________________________

NREMT # ____________ Colorado EMT # ____________

**II. Current Practice Setting(s)**

A. Primary Mesa County EMS Agency
_____________________________________

Physical Address: __________________________________________________
Mailing Address: __________________________________________________

Phone: ___________________ Fax: ____________________

Name of Officer/Supervisor: ____________________ Title: _________________

Supervisor Phone: ____________________ Start Date: ________________

B. Are you currently affiliated with any other agency? ☐ Yes ☐ No

Agency: ____________________________________ Start Date: ____________
Address: ________________________________________
Medical Director: ________________________________________
MD Phone: __________________________________
Officer/Supervisor: _________________________ Phone: _______________

Agency: ____________________________________ Start Date: ____________
Address: ________________________________________
Medical Director: ________________________________________
MD Phone: __________________________________
Officer/Supervisor: _________________________ Phone: ________________

*Please make copies of this section and submit with application if additional space is needed.*

**III. EMS Certification** *List all EMS certifications (NREMT, any and all state certification).*

A. Provider level (EMT-B, EMT-A, EMT-I, EMT-P): _______________

B. Certifications/Registrations:

Type of Certificate or Registration: ____________________________ ☐ Active
Number: __________________ ☐ Inactive/Expired
State/Institution: ___________________ ☐ Pending
Expiration Date: ____________ Issue Date: ____________ Date Relinquished: _________

Type of Certificate or Registration: ____________________________ ☐ Active
Number: __________________ ☐ Inactive/Expired
State/Institution: ___________________ ☐ Pending
Expiration Date: ____________ Issue Date: ____________ Date Relinquished: _________

Type of Certificate or Registration: ____________________________ ☐ Active
Number: __________________ ☐ Inactive/Expired
State/Institution: ___________________ ☐ Pending
Expiration Date: ____________ Issue Date: ____________ Date Relinquished: _________

Type of Certificate or Registration: ____________________________ ☐ Active
Number: __________________ ☐ Inactive/Expired
State/Institution: ___________________ ☐ Pending
Expiration Date: ____________ Issue Date: ____________ Date Relinquished: _________

**IV. Education Since High School**

A. Education: *List in chronological order beginning with the earliest.* Not Applicable ☐

☐ Undergraduate ☐ Graduate

Complete School Name: ______________________________________________________
Degrees/Certification Received: _____________________ Graduation Date: ____________
Course of Study or Major: ___________________________________________________
Address: _______________________________________________________________
Email: _____________________ Phone: _________________ Fax: __________________
Dates Attended: From ____________ To ______________

☐ Undergraduate ☐ Graduate

Complete School Name: ______________________________________________________
Degrees/Certification Received: _____________________ Graduation Date: ____________
Course of Study or Major: ___________________________________________________
Address: _______________________________________________________________
Email: _____________________ Phone: _________________ Fax: __________________
Dates Attended: From ____________ To ______________

☐ Undergraduate ☐ Graduate

Complete School Name: ______________________________________________
Degrees/Certification Received: ___________________ Graduation Date: ____________
Course of Study or Major: _______________________________________________
Address: ___________________________________________________________
Email: ___________________ Phone: ________________ Fax: ________________
Dates Attended: From ___________ To _____________

*Please make copies of this section and submit with application if additional space is needed.*

B: Other Clinical Training Programs: *List those pertinent to EMS.* Not Applicable ☐

Institution Name: ______________________________________________________
Address: ___________________________________________________________
Dates Attended: From ___________ To ____________ Date Completed: _____________
Course of Study: ______________________________ Certificate Awarded: ____________
Program Completed? Yes☐ No☐ If no, attach letter of explanation.
Name of Program Director: ____________________________ Phone: ________________
Fax: _______________________ Email: _______________________________________

Institution Name: ______________________________________________________
Address: ___________________________________________________________
Dates Attended: From ___________ To ____________ Date Completed: _____________
Course of Study: ______________________________ Certificate Awarded: ____________
Program Completed? Yes☐ No☐ If no, attach letter of explanation.
Name of Program Director: ____________________________ Phone: ________________
Fax: _______________________ Email: _______________________________________

Institution Name: ______________________________________________________
Address: ___________________________________________________________
Dates Attended: From ___________ To ____________ Date Completed: _____________
Course of Study: ______________________________ Certificate Awarded: ____________
Program Completed? Yes☐ No☐ If no, attach letter of explanation.
Name of Program Director: ____________________________ Phone: ________________
Fax: _______________________ Email: _______________________________________

*Please make copies of this section and submit with application if additional space is needed.*

C. Other Certifications: (*ACLS, PALS, PEPP, ITLS, NRP, etc.*) Not Applicable ☐

Certification: __________________________ Expiration Date: ______________
Certification: __________________________ Expiration Date: ______________
Certification: __________________________ Expiration Date: ______________
Certification: __________________________ Expiration Date: ______________
Certification: __________________________ Expiration Date: ______________
Certification: __________________________ Expiration Date: ______________

D. Faculty Positions: *List any EMS teaching positions you have held.* Not Applicable ☐

Institution Name: ________________________________ Title: ____________________
Address: ______________________________________________________________
Dates: From ____________ To ____________ specialty: _________________________
Contact: _____________________________________ Title: _____________________
Phone: _______________ Fax: ______________ Email: __________________________

Institution Name: ________________________________ Title: ____________________
Address: ______________________________________________________________
Dates: From ____________ To ____________ specialty: _________________________
Contact: _____________________________________ Title: _____________________
Phone: _______________ Fax: ______________ Email: __________________________

Institution Name: ________________________________ Title: ____________________
Address: ______________________________________________________________
Dates: From ____________ To ____________ specialty: _________________________
Contact: _____________________________________ Title: _____________________
Phone: _______________ Fax: ______________ Email: __________________________

E. Please list any other education related to EMS or the medical field. *If none, leave blank.*
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

**V. Endorsements** *(I.V., critical care, community paramedic)* Not Applicable ☐

A. State of Colorado Endorsements:

Endorsement: __________________________________ Date: ___________________
Expiration Date: ________________ Recertification Date: _______________

Endorsement: __________________________________ Date: ___________________
Expiration Date: ________________ Recertification Date: _______________

Endorsement: __________________________________ Date: ___________________
Expiration Date: ________________ Recertification Date: _______________

B. Additional Endorsements/Qualifications (any other state or territory) Not Applicable ☐

Endorsement/Qualification: ____________________________________________
State/Territory: ____________________________ Date: ___________________
Expiration Date: _________________ Recertification Date: __________________

Endorsement/Qualification: ____________________________________________
State/Territory: ____________________________ Date: ___________________
Expiration Date: _________________ Recertification Date: __________________

Endorsement/Qualification: ____________________________________________
State/Territory: ____________________________ Date: ___________________
Expiration Date: _________________ Recertification Date: __________________

**VI. Prior EMS Agency Affiliations** Not Applicable ☐

A. Current Primary Mesa County Agency(from section II): __________________________

B. List in reverse chronological order prior EMS agency affiliations in the past 10 years:

Agency: __________________________________ From ________ To _______
Address: ____________________________________________
Medical Director: ____________________________________________
MD Phone: ____________________________________
Officer/Supervisor: ___________________________ Phone: ________________

Agency: __________________________________ From ________ To _______
Address: ____________________________________________
Medical Director: ____________________________________________
MD Phone: ____________________________________
Officer/Supervisor: ___________________________ Phone: ________________

Agency: __________________________________ From ________ To _______
Address: ____________________________________________
Medical Director: ____________________________________________
MD Phone: ____________________________________
Officer/Supervisor: ___________________________ Phone: ________________

Agency: __________________________________ From ________ To _______
Address: ____________________________________________
Medical Director: ____________________________________________
MD Phone: ____________________________________
Officer/Supervisor: ___________________________ Phone: ________________

*Please make copies of this section and submit with application if additional space is needed.*

**VII. Other Medical Work History** Not Applicable ☐

A. List all non-EMS medical work history (phlebotomist, tech, etc.) for the past 10 years:

Employer: ________________________________________________
From ____________ To ___________ Title/Position: _________________________________
Address: _________________________________________________
Contact: ______________________________________ Title: _________________________
Phone: ___________________________ Fax: ____________________________
Email: _______________________________________________________

Employer: ________________________________________________
From ____________ To ___________ Title/Position: _________________________________
Address: _________________________________________________
Contact: ______________________________________ Title: _________________________
Phone: ___________________________ Fax: ____________________________
Email: _______________________________________________________

Employer: ________________________________________________
From ____________ To ___________ Title/Position: _________________________________
Address: _________________________________________________
Contact: ______________________________________ Title: _________________________
Phone: ___________________________ Fax: ____________________________
Email: _______________________________________________________

Employer: ________________________________________________
From ____________ To ___________ Title/Position: _________________________________
Address: _________________________________________________
Contact: ______________________________________ Title: _________________________
Phone: ___________________________ Fax: ____________________________
Email: _______________________________________________________

Employer: ________________________________________________
From ____________ To ___________ Title/Position: _________________________________
Address: _________________________________________________
Contact: ______________________________________ Title: _________________________
Phone: ___________________________ Fax: ____________________________
Email: _______________________________________________________

*Please make copies of this section and submit with application if additional space is needed.*

**VIII. Peer References** If new to EMS, check here and continue to next section ☐

A. Please list three (3) references, from professional peers who through recent observations have personal knowledge of your professional competence, conduct, and work ethics.

Name: ______________________________________ Relationship: ___________________________
Dates of Association: __________________________ Title________________________________
Email: ____________________________________________________ Phone: ________________

Name: _______________________________________ Relationship: ___________________________
Dates of Association: __________________________ Title_________________________________
Email: ___________________________________________________ Phone: ________________

Name: _______________________________________ Relationship: ___________________________
Dates of Association: __________________________ Title_________________________________
Email: ___________________________________________________ Phone: ________________

**IX. Required Mesa County EMS System Education** *For re-credentialing only.*

A. Please complete the applicable sections for the past 24 months:

BLS Skills date completed: ________________ ALS Skills date completed: ________________
BLS Skills date completed: ________________ ALS Skills date completed: ________________

Squad Review date completed: _____________ Squad Review date completed: _____________
Squad Review date completed: _____________ Squad Review date completed: _____________
Squad Review date completed: _____________ Squad Review date completed: _____________

## Attestation Questions

This is to be completed by the provider applying for re-credentialing. Modification to the wording or format of these Attestation Questions will invalidate the Application.

Please answer the following questions “yes” or “no”. If your answer to any of the following questions is “yes”, please provide details and reasons including dates, as specified in each question, on an Explanation Form and attach to the Application.

For the purposes of the following questions, the term “adverse action” means a voluntary or involuntary termination, loss of, reduction, withdrawal, limitation, restriction, suspension, revocation, denial, surrender, resignation, relinquishment, reprimand, censure, sanction, subject to probation, placed under special or intensified review, withdrawn or failed to proceed with an application, denied or recommend for denial, any such action in progress, or non-renewal of membership, clinical privileges, academic affiliation or appointment or employment. “Adverse action” also means with respect to professional licensure registration or certification, any previously successful or currently pending challenges to such licensure, registration or certification including any voluntary or involuntary restriction, suspension, revocation, denial, surrender, non-renewal, admonishment, public or private reprimand, probation, consent order, reduction, withdrawal, limitation, relinquishment, or failure to proceed with an application for such licensure, registration or certification.

1. To your knowledge, have you ever been the subject of an adverse action (or is an investigation or adverse action currently pending) by:
    a. a hospital or other healthcare facility? Yes _____ No _____

b. an education facility or program? Yes _____ No _____
c. a professional organization or society? Yes _____ No _____
d. a professional licensing/certification body? Yes _____ No _____

2. Have you ever voluntarily or involuntarily resigned, terminated or surrendered medical staff privileges or employment from a hospital, group practice, other healthcare facility, or EMS agency? Yes ____ No _____
   a. If the answer to the above question is "yes", was it to avoid disciplinary action or investigation or while under investigation, or is such an investigation pending? Yes _____ No _____
3. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony or misdemeanor that is reasonably related to your qualifications, competence, functions, or duties as a health care professional or are you currently under indictment or currently have pending against you any such charges? Yes _____ No _____

4. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony or misdemeanor that alleged fraud, an act of violence, child abuse, or a sexual offense or sexual misconduct or are you currently under indictment or currently have pending against you any such charges?
   Yes _____ No _____
5. In the last 10 years, have you been found liable or responsible for or named in any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a healthcare professional or that alleged fraud, an act of violence, child abuse, or sexual offense or sexual misconduct?
   Yes _____ No _____
6. Have you ever been court- martialed for actions related to your duties as a health care professional? Yes _____ No _____

By signing this Application, I certify, agree, understand and acknowledge the following:

1. The information in this entire application, including all subparts and attachments, is complete, current, correct, and not misleading.
2. Any misstatements or omissions (whether intentional or unintentional) on this Application may constitute cause for a denial of my Application or summary dismissal or termination of my clinical privileges, membership, or practitioner participation agreement without right of hearing.
3. A photocopy of this Application, including this attestation, the authorization and release of information form and any or all attachments has the same force and effect as the original.
4. I have reviewed the information in this Application on the most recent date indicated below and it continues to be true and complete.
5. While this Application is being processed, I agree to update the information originally provided should there be any change in that information.

6. No action will be taken on this Application until it is complete and all outstanding questions with respect to the Application have been resolved.

Printed Name: _______________________________________
Sign*: ______________________________________
Date: ____________________________

**If submitting electronically, type full legal name in this field. I understand this is my signature and carries the same authority and understanding as my printed hand.*

**MESA COUNTY EMS SYSTEM**
**COLORADO HEALTH CARE PROFESSIONAL CREDENTIALS APPLICATION**
**AUTHORIZATION AND RELEASE OF INFORMATION FORM**
**(Modified Releases Will Not Be Accepted)**

***By submitting this application, including all subparts and attachments, I acknowledge, understand, consent, and agree to the following:***

1. As an applicant for medical staff membership in the Mesa County EMS System, hereby referred to as the entity/agency, indicated on this application, I have the burden of producing adequate information for proper evaluation of this application.

2. I also understand that I have the continued responsibilities to resolve any questions, concerns, or doubts regarding any and all information in this application. If I fail to produce this information, I understand that the entity/agency will not be required to evaluate or act upon this application. I also agree to provide updated information as may be required or requested by the entity/agency or its authorized representatives or designated agents.

3. The entity/agency and its authorized representatives or designated agents will investigate the information in this application. I consent and agree to such investigation and to disciplinary reporting and information exchange activities of the entity/agency as part of the verification and credentialing process.

4. I specifically authorize the entity/agency and its authorized representatives and designated agents to obtain and act upon information regarding my competence, qualifications, education, training, professional and clinical ability, character, conduct, ethics, judgement, mental and physical health status, emotional stability, utilization practices, professional licensure of certification, and any other matter related to my qualification or matters addressed in this application (my "qualifications).

5. I authorize all individuals, institutions, schools, programs, entities, facilities, hospitals, agencies, societies, associations, companies, licensing authorities, boards, organizations or others with which I have had association, who may have information bearing on my qualifications to consult with the entity/agency and its authorized representatives and designated agents and to report, release, exchange, and share information and documents with the entity/agency, for the purposes of evaluating this application and my qualifications.

6. I consent to and authorize the inspection of appropriate records and documents that may be material to an evaluation of this application and my qualifications and abilities to carry out the clinical privileges/service/participation I have requested. I authorize each and every individual and organization with custody of such records and documents to permit such inspection and copying as may be necessary for the evaluation of this application. I also agree to appear for interviews, if required or requested by the entity/agency in regard to this application.

7. I further consent to and authorize the release by the entity/agency to other entities/agencies and interested persons on request of information the other entity/agency may have concerning me (including but not limited to peer review information which is provided to another entity/agency for peer review purposes), as long as in each instance such release of information is done in good faith without malice. I hereby release from liability the entity/agency and its authorized representatives and designated agents

from any claim for damages of whatever nature for any release of information made in good faith by the entity/agency or its representatives or designated agents.

8. I release from any liability, to the fullest extent permitted by law, all persons and entities for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims of whatever nature against the entity/agency and its representatives and designated agents acting in good faith and without malice in connection with the investigation of this application and my qualifications.

9. For entity/agency membership and privileges, I acknowledge that I have been informed of or have been given the opportunity to review all rules, regulations, resolutions, protocols, policies, and procedures of the entity/agency (Mesa County EMS System), and I hereby agree to abide by them. I agree to conduct my practice in accordance with applicable laws and ethical principles of my profession.

10. I acknowledge that any investigation, actions, or recommendations of any committee or the governing body of the entity/agency with respect to the evaluation of this application and any periodic reappraisals or evaluations will be undertaken as a medical review and/or peer review committee and in fulfillment of the entity/agency obligations under Colorado law to conduct a review of professional practices, and are therefore entitled to any protections provided by law.

11. I have read and understand this authorization and release of information form. A photocopy of this authorization and release of information form shall be as effective as the original and shall constitute my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application. This authorization and release shall apply in connection with the evaluation and processing of this application as well as in connection with any periodic reappraisals and evaluation undertaken. I agree to execute such additional releases as may be required from time to time in connection with such periodic reappraisals and evaluations.

12. I understand that I have an opportunity to review the information submitted in support of this application pursuant to the entity/agency policies regarding review. If during the process of credentialing, the entity/agency receives information that varies substantially form information I have provided, I will be notified of this and will have an opportunity to correct erroneous information. I have the right, upon request, to be informed of the status of my application.

## Authorization and release of information

Please Print Your Name_______________________________________________
Sign*_______________________________________________
Date_________________________________

*If submitting electronically, type full legal name in this field. I understand this is my signature and carries the same authority and understanding as my printed hand.*

To be completed by your **primary** EMS Agency in Mesa County:

I, the undersigned, being a duly appointed representative of the:

______________________________________________________________
Mesa County EMS Agency

hereby approve this application and affirm that the aforementioned applicant is in good standing with the above agency and has complied with all requirements for continued membership, voluntary or paid employment, and that there are no pending investigations or adverse actions involving clinical care or moral turpitude since the last re-credentialing process which have not been previously disclosed.

Title: ______________________________________
Printed Name: __________________________________
Sign*: ____________________________________
Date: _______________________

**By typing my initials in this field, I understand this is my signature and carries the same authority and understanding as my printed hand.*

To be completed by Mesa County EMS Coordinator / Medical Director:

This application for re-credentialing by the above named EMS provider has been:

Approved _____ Submitted for Further Review _____ Denied ____

___________________________ _____________
Mesa County EMS Coordinator Date

___________________________ _____________
Mesa County Medical Director Date