

**South Dakota State Board of Medical and Osteopathic Examiners
Advanced Life Support Training Application for Student Status**

Last Name _____ First Name _____ MI _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Social Security Number _____ Date of Birth _____

Highest Level of Education:

GED 12 13 14 15 16 Other _____

Primary Occupation _____

Have you ever been convicted of a Felony? Yes _____ No _____

Have you ever had your certification suspended or revoked? Yes _____ No _____

Have you ever had disciplinary action taken against your EMT Certification Yes _____ No _____

If you have answered yes to any of the above questions please complete the following:

What was the nature of the offense? _____

What state was the offense committed? _____

Sentence _____

What is the current status? _____

Disposition? _____

The following questions pertain to your EMT-Basic Education

Name of Training Facility _____

Date of Completion _____ City _____ State _____ Zip _____

Course Coordinator _____

SD EMT number _____ Issued _____ Expires _____

The following questions pertain to your current EMS employment

What service are you currently employed with? _____

Address of employment _____

City _____ State _____ Zip _____

I have served as an EMT-B from _____ to _____ for a total of _____ months.

Private

Fire Department
Police Department
EMS Division
Hospital
Other,

Municipal

Commercial
Hospital
Industrial
Industrial
Funeral Home
Other,

Volunteer

Fire Department
EMS Corps
Rescue Squad
Other,

Military

Air Force
Army
Coast Guard
Navy
Other,

Government

Park Service
Park Ranger
Other,

I have tentatively been accepted to begin: (circle one) EMT-Intermediate/85 EMT-Intermediate/99
or the EMT Paramedic - level of Advanced Life Support Training

at: _____ (Name of Training Institution or Agency)

in the city of _____ and state _____ on the date of _____.

Please provide the name and address of three (3) references the Board may contact.
(One must be a local Physician)

1. Name _____

Address _____

City _____ State _____ Zip _____

2. Name _____

Address _____

City _____ State _____ Zip _____

3. Name _____

Address _____

City _____ State _____ Zip _____

Applicant's Statement

I hereby affirm and declare that the above information is true and correct and that any fraudulent entry may be considered a sufficient cause for rejection. I further authorize the Board or its designated agent to investigate any information contained herein they may deem necessary.

Applicant's Signature

Date

To: L. Paul Jensen, Chief Executive Officer
South Dakota State Board of Medical and Osteopathic Examiners

From: Director of Ambulance Service

Directors Name _____

Name of Service _____

Address _____

City _____ State _____ Zip _____

Re: Verification of Ambulance Affiliation

This is to verify that _____ is an active member of
this ambulance service serving as a:

_____ full time

_____ part time

_____ volunteer

and has been serving in that position for the last _____ months.

If accepted into Advanced Life Support Training, he/she will continue affiliation with this
ambulance. I understand if he/she leaves or is relieved by this service it is my responsibility to
notify the Board of Examiners in writing immediately.

Director's Signature

Date

To: L. Paul Jensen, Chief Executive Officer
South Dakota State Board of Medical and Osteopathic Examiners

From: Medical Director of ALS Class

Medical Director _____

Address _____

City _____ State _____ Zip _____

From: Course Coordinator of ALS Class

Course Coordinator _____

Address _____

City _____ State _____ Zip _____

Re: Verification of Acceptance into Training

This is to verify that _____ has been tentatively accepted

into the: (circle one) EMT-Intermediate/85 EMT-Intermediate/99 EMT-Paramedic

Advanced Life Support Training program to be conducted _____
(Name of Training Institution or Agency)

in the city of _____ state _____ beginning on the date
of _____.

This training program has been approved by the Board of Medical and Osteopathic Examiners and
the above mentioned person has met the student criteria established for the program.

Medical Director Signature _____ Date _____

Course Coordinator Signature _____ Date _____