

Rhode Island Department of Health Center for Emergency Medical Services 3 Capitol Hill, Room 105

Providence, RI 02908-5097

Instructions and Application To Operate an **EMS Training Institution**

Select the level of EMS Training Institution license you are applying for (check one):

ne: (401) 222-2401	Fax: (401) 222-6683	TTY/TDD: (800) 745-555
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Ву:		
ee Received	Approved Denied	Da <u>te:</u>
	FOR DEPARTMENT OF HEALTH US	SE ONLY
	Training Institution Name	
		,
	Emergency Medical Respor	nder (EMR)
	Emergency Medical Technic	cian (EMT)
	Advanced Emergency Medi	cal Technician (AEMT)
	Advanced Emergency Medi	cal Technician - Cardiac (AEMT-C)
	Paramedic	

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***Detach Page - Do Not Submit With Application ***

GENERAL INFORMATION

- 1. Requirements for licensure are established by the Rules and Regulations Rules and Regulations 216-RICR-20-10.2, available through the Center for EMS website at http://www.health.ri.gov/licenses
- EMS licensure can be denied pursuant to the provisions of the Regulations Rules and Regulations 216-RICR-20-10.2. Statements or documents may be considered sufficient cause to deny or revoke a license as an EMS Training Institution in Rhode Island and may result in additional penalties as deter mined by law.
- 3. Should you have any questions regarding the license requirements or completion of the application form, contact the Center for Emergency Medical Services at (401) 222-2401.

APPLICATION INSTRUCTIONS

- 1. Complete all application materials as instructed. Please answer all questions. Incomplete questions or incomplete applications will not be processed and will be returned to you for correction and re-submission. Please mark "NA" on questions that are Not Applicable. Please type this application using the fillable form online then print the completed application.
- 2. Do not detach any full pages from this application packet.
- 3. Sign the application and return it with the application fee in the amount of \$1,500.00, payable to the General Treasurer, State of Rhode Island.
- 4. Do not submit the application without all applicable information, documentation and fee(s).

REQUIRED DOCUMENTATION

- Written curriculum policies, and procedures consistent with the National EMS Education Standards.
- Current written agreements and/or contracts for clinical and field internships
- Documentation of official affiliation with one of the following:

Four-year college or university;

Two-year technical or community college;

Hospital or medical center:

Federal, state, county, or local government entity; or

A public or private corporation that meets the state and local business requirements

- Paramedic Level Institutions must submit a copy of their accreditation or Letter of Review from the Commission on Accreditation of Allied Health Education Programs (CAAHEP).
- Photostatic copy of Program Director's Associate's degree from an accredited institution of higher education if conducting EMT or Advanced EMT-Cardiac courses, or a Bachelor's degree from an accredited institution of higher education if conducting Paramedics program.

Submit the completed application and all required materials to:

Rhode Island Department of Health Center for Emergency Medical Services Room 105, 3 Capitol Hill Providence, RI 02908-5097



State of Rhode Island **Division of Emergency Medical Services**Application for Training Institution

Refer to t	the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.
1. Name of Training Institution:	Name of Training Institution
2. Contact Person: Provide the name of the person to contact regarding this training institution.	First Name Middle Name Surname, (Last Name)
3. FEIN/SSN: Provide the FEIN (Federal Employee Identification Number. If you are a sole proprietor this number may be your Social Security Number.	Federal Employer Identification Number (FEIN) OR NOTE: If you are the sole proprietor of a facility or business, then you must supply your Social Security Number (SSN) and date of birth. If you are an individual representing a facility or a business that is seeking licensure, then you must supply the Federal Employer Identification Number (FEIN) for the facility or the business. THIS INFORMATION IS MANDATORY Owner Date of Birth
4. Mailing Information: Please provide the mailing information for all communication regarding this license. It	First Line Address Second Line Address
is your responsibility to notify the Center of all address changes.	Third Line Address City State/Province Zip Code Country, If NOT U.S. Postal Code, If NOT U.S.
	Mailing Address Phone Extension Mailing Address Fax Email Address (Format for email address is Username@domain e.g. applicant@isp.com)
5. Location Information:	First Line Address
Please provide the physical location information for this training institution. It is your responsibility to notify the Center of all address changes.	Second Line Address Third Line Address City State/Province Zip Code
This information will appear on the HEALTH website.	Country, If NOT U.S. Postal Code, If NOT U.S. Mailing Address Phone Extension Mailing Address Fax Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

ant: Print your com	plete training institution name_>		
6. Type of Ownership	☐ Corporation	☐ Limited Liability Company	☐ Partner
Please Check ONE	Sole Proprietorship Complete Section 8 Below	Limited Partnership	☐ Partnership
	☐ Governmental Entity	Other (Describe):	
7. Ownership Information	Name of Owner		
for "privately			
held" organizations:	D.B.A. (Doing Business As)		
organizations.	First Line Address		
Provide the name			
address and tele- phone number(s) of	Second Line Address		
the facility/business owner in the spaces			
provided.	Third Line Address		
	City	State/Province Zip Code	
	Country, If NOT U.S.	Postal Code, If <u>NOT</u> U.S.	
	Phone	Extension Fax	
	Email Address (Format for email address is Usernar	ne@domain e.g. applicant@isp.com)	
		ou must include a BCI supported by t	
8. Sole proprietor Information:	application. Has the sole proprietor ever bee		
If you are the sole proprietor of this service please complete this section. Attach additional 8 1/2 x 11 sheets as needed.	of federal or state law (Felony or (If yes, explain)		
	Sole proprietor's Experience in E	IVIS	

Applicant:	Print your complete training institution name >	
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9. Key Personnel:

Provide the name, phone number and email address for the specified personnel at your training institution.

10. Affidavit of Applicant

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public have completed all components accurately and completely.

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Applicant: Print your complete training institution name >

Level **Full Time** License Number Part Time Name **Faculty** Roster: Name License Number Level **Full Time** Part Time Name License Number Level **Full Time** Part Time List names and license numbers Name License Number Level **Full Time** Part Time of all personnel employed at this training institution. Name License Number Level Full Time Part Time Make copies of this page and attach if necessary. Full Time Name License Number Level Part Time Name License Number Level **Full Time** Part Time Name License Number Full Time Part Time Level License Number **Full Time** Part Time Name Level **Full Time** Name License Number Level Part Time **Full Time** License Number Level Part Time Name Name License Number Level **Full Time** Part Time Name Full Time License Number Level Part Time License Number Full Time Part Time Name Level License Number Full Time Name Level Part Time **Full Time** Part Time Name License Number Level License Number Level **Full Time** Part Time Name Full Time Part Time Name License Number Level License Number Name Level **Full Time** Part Time