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| **DEPARTMENT OF HEALTH SERVICES**Division of Public HealthF-00614 (09/2019) | **STATE OF WISCONSIN**Office of Preparedness and Emergency Health CareWis. Stat. § 256.15608-266-1568 |
| **PHYSICIAN, PHYSICIAN ASSISTANT, AND REGISTERED NURSE****EQUIVALENCY APPLICATION** |
| Completion of this form is required under the provisions of Wis. Stat. § 256.15 in order to verify qualification to act as part of a legal ambulance crew. Personally identifiable information requested on this form will only be used for verification and tracking purposes. Provision of your social security number is required and is used by the Bureau of Communicable Disease and Emergency Response only as an identifier in the database. Return completed form and necessary attachments to, Bureau of Communicable Disease and Emergency Response, 1 W Wilson St., P O Box 2659, Madison, WI 53701-2659. |
| **APPLICANT INFORMATION** |
| **Last Name**      | **First Name**      | **MI**  | **Former Name(s)**      |
| **Mailing Address**      |
| **City**      | **State**   | **Zip Code**      | **County**      | **Social Security Number (Required)**      |
| **Daytime Telephone Number**      | **Other Telephone Number**      | **Birth Date (Month/Day/Year)**      | **Gender****[ ]**  Male**[ ]** Female |
| **Wisconsin MD, PA or RN License Number**      | **Expiration Date (Month/Day/Year)**      | **E-Mail Address**      |
| **Wisconsin EMT License Number**      | **Expiration Date (Month/Day/Year)**      | **EMT License Level**      |
| **SERVICE INFORMATION** |
| Service Name      |
| License Level of Service      | Authorized Practice Level (Per Medical Director)      |
| **APPLICANT CERTIFICATION** |
| I have reviewed the current Wisconsin Scope of Practice policy for EMS providers. I have provided documentation of equivalent education, and demonstrated competencies, for all skills based on the Wisconsin EMS provider level of which I will be functioning. This has been approved by the medical director as indicated below. I understand that I may only function to the level of the EMS service’s authorization or the level of the EMS provider identified on this form.I certify that the above information is true and complete, that I meet the qualifications for staffing under s. 256.15, Wis. Stats. and Chapter DHS 110, Wis. Admin. Code, at the level indicated above. I understand that providing false or misleading information may result in the denial, probation, suspension, or revocation of my authorization to function as an EMS provider. **SIGNATURE** - Applicant Date Signed |
| **SERVICE CERTIFICATION** |
| I certify that the above named applicant is affiliated with the service provider as listed above and has met the requirements for staffing as outlined in s. 256.15, Wis. Stats. and Chapter DHS 110, Wis. Admin. Code. In addition they will function as outlined in our ambulance service operational plan as filed with the Bureau of Local Health Support and Emergency Medical Services. **SIGNATURE** - Service Director Date Signed |
| **MEDICAL DIRECTOR CERTIFICATION** |
| I have reviewed the documentation presented by the above Applicant and determined that this individual has completed the education and skill training equivalent to, or greater than, the Wisconsin EMS level identified. I understand that the applicant may not function above the level of the service’s authorization. As Medical Director I hereby approve the applicant to provide care at the level identified on this form. **SIGNATURE** - Medical Director Date Signed |

***Note***: Approval of this application does not constitute Wisconsin EMS provider certification. EMS certification is obtained by successful completion of an approved EMS program.